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ATTITUDINAL AND PERCEPTUAL BARRIERS TO

ACCESSING MENTAL HEALTH SERVICES

AMONG MEMBERS OF THE

U.S. AIR FORCE

by

Fred P. Stone

A dissertation submitted to the faculty of
The University of Utah
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Graduate School of Social Work

The University of Utah

June 1998

THE UNIVERSITY OF UTAH GRADUATE SCHOOL

SUPERVISORY COMMITTEE APPROVAL

of a dissertation submitted by

Fred P. Stone

This dissertation has been read by each member of the following supervisory committee and by majority vote has been found to be satisfactory.

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FINAL READING APPROVAL

To the Graduate Council of the University of Utah:

I have read the dissertation of _Fred P. Stone_ in its final form and have found that
(1) its format, citations, and bibliographic style are consistent and acceptable; (2) its
illustrative materials including figures, tables, and charts are in place; and (3) the final
manuscript is satisfactory to the supervisory committee and is ready for submission
to The Graduate School.

May 11, 1995
Date

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ABSTRACT

A random sample of 1,000 members of the U.S. Air Force (USAF) was
surveyed concerning attitudinal and perceptual barriers to accessing mental health
services in the military. Three hundred ninety-one people returned the survey.
They reported their perception that seeking mental health services in the military
system has a negative impact on careers and is highly stigmatizing. The sample
also indicated that the military mental health system offers no more confidentiality
than conversations with friends and that military mental health professionals are no
more qualified to help with personal problems than friends or physicians and, in
fact, are less qualified than chaplains. The greatest barriers to accessing mental
health services were the embarrassment associated with help seeking and cultural
bias against help seeking. The Attitude Towards Seeking Professional
Psychological Help (ATSPPH) scale, which is a part of the survey, indicated that
USAF members have more negative views of help seeking than their civilian
counterparts. An analysis of 121 survey comments confirmed these results.
Suggestions to change the perception of the military mental health system, as well
as the system itself, are discussed.

To Shirley,

I was troubled, you gave me peace.
I was empty, you made me full.
I was dead, you brought me back to life.

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ACKNOWLEDGMENTS

So many factors influence the creation of a dissertation. Each is unique, but all are essential. Those whom I have worked with closely certainly share the credit, but the people I wish to thank the most are nameless. They are the 391 USAF members who filled out the survey and returned it. With some trepidation, many talked about their mental health problems and concerns as if I was one of the few people they believed they could trust. Others accused the USAF mental health system of being part of some greater conspiracy, and a few even accused me of complicity with this system. Many wished me well, whereas others told me to read my Bible or leave them alone. All their responses and comments were essential to the completion of this project, and their contribution to understanding the military mental health system is invaluable.

I must also thank the dissertation committee who was so supportive throughout this process: O. William Farley, Au-Deane S. Cowley, Frederick V. Janzen, Ted Packard, Larry L. Smith, and F. Ted Hebert. Their ability to cooperate and complement each other made working with them a pleasure. I especially want to express gratitude to Bill Farley, chair, who was always there with support to allay my often obsessive-compulsive tendencies toward this work and with advice during this sometimes confusing process. His willingness to mentor me through this process was the key to its timely completion. I also

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Unlike some doctoral students, my experience at the University of Utah has been a delight that is due in large part to the commitment the professors of this program have to each student completing his or her degree. In my experience, they never placed their own needs above mine and that is truly rare in the academic world. For that, I am grateful.

CHAPTER I

INTRODUCTION

The social work profession has been dedicated to helping others overcome problems for the last 150 years. Social workers have advocated to protect children from abuse, sought policy solutions to overcome poverty, and fought for equal opportunities for the oppressed (Specht & Courtney, 1994). Social workers are continuing this tradition of helping others and are increasingly focusing their efforts in the area of mental health (Fellin, 1996; Specht & Courtney, 1994). Currently, social workers provide half of the mental health services in the United States (National Association of Social Workers, 1996a).

Mental health problems in the United States are substantial. Approximately one fourth of the general population has a significant mental health problem (Neugebauer, Dohrenwend, & Dohrenwend, 1980), but only one fourth of those receives mental health services (Link & Dohrenwend, 1980). Despite the fact that mental health services are available and effective (Lambert & Bergin, 1994), most people with significant mental health problems never seek formal mental health treatment (Horwitz, 1987).

Numerous researchers (Horwitz, 1977; Knesper, Pagnucco, & Wheeler, 1985; Veroff, Kulka, & Douvan, 1981) have posited a variety of reasons why people avoid seeking formal mental health care. Some people avoid help because

their culture discourages it, whereas others simply cannot afford mental health care. Regardless of the reason, social workers need to understand why people avoid mental health services if they are going to formulate a strategy to help more people access these services.

The present study examined this problem with a specific population: active-duty members of the U.S. Air Force (USAF). A plethora of mental health services is available to active-duty USAF members, but the consensus among military leaders and social workers is that significant barriers prevent many of its members from accessing these services (Jordan, 1996; Jowers, 1996a).

Problem Statement

The military holds a unique position in the United States. Prior to World War II, the military was virtually a separate culture from the balance of society (Janowitz, 1960). After the war, however, the military became more integrated into the mainstream of the American culture (Janowitz, 1960); in fact, today, the daily activities of the military are regular features in the news and the subject of much debate.

The new openness of the military has brought more awareness to the unique mental health needs and problems of people in the military. Among these problems is a rising number of suicides (Helmkamp, 1995; Jowers, 1996a), increasing rates of domestic violence (Jowers, 1996b), substantial alcohol abuse (Bray et al., 1992), and other mental health problems related to war (Weaver & Stewart, 1988).

Mental health problems among military members are substantial. Despite the fact that all active-duty military members have access to free mental health services, the rate of mental health services utilization is low (Bray et al., 1992). Therefore, some barriers or impediments must be preventing them from accessing these services.

Purpose of the Study

The purpose of this study was to further the understanding of barriers to accessing mental health services of USAF members by examining their attitudes and perceptions towards these services.

Research Questions

Four research questions guided this investigation:

1. Are there substantial differences between the general attitudes toward seeking mental health services among USAF members and those among civilians?

2. Are there significantly more barriers to seeking help from military mental health professionals than from chaplains, commanders, physicians, or friends? More specifically,

    a. Do USAF members fear negative repercussions on their careers from seeking military mental health services compared to seeking help from chaplains, commanders, physicians, or friends?

b.   Do USAF members believe that they have less confidentiality when talking about personal or emotional problems with a military mental health professional compared to talking with chaplains, commanders, physicians, or friends?

c.   Do USAF members have less confidence in the abilities of military mental health professionals than those of chaplains, commanders, physicians, or friends?

d.   Do USAF members perceive those who seek mental health services as being "weaker" than those who seek help from chaplains, commanders, physicians, or friends?

e.   Do USAF members perceive a greater stigma or more embarrassment in seeking help from mental health professionals compared to seeking help from chaplains, commanders, physicians, or friends?

f.   What is the perception among USAF members of the availability of mental health services in the USAF?

3.   Are there substantial differences in the attitudes toward seeking mental health services among USAF members with regard to rank, gender, marital status, years of service, and Air Force Service Code (AFSC)?[1]

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[1]AFSC is the code assigned to all USAF members. This code represents the duties assigned to each member.

4.   Are there substantial differences between the attitudes toward help

seeking of those who have voluntarily sought mental health services,

of those coerced or forced to seek mental health services, and of

those who have considered going but have not? What is the

prevalence of USAF members who have sought mental health

services from a civilian mental health provider? What are the

attitudes and perceptions of those who have sought mental health

services from civilian providers?

Organization of This Dissertation

This dissertation is separated into six chapters. Chapter I examined the

purpose of this dissertation and presented the central research questions. Chapter

II provides the rationale for this study by examining the prevalence of mental

health problems, utilization of mental health services, and barriers to accessing

those services in the civilian and military communities. Chapter III looks at the

demographic characteristics of "typical" help seekers in the civilian community and

members of the USAF. In addition, three theoretical perspectives were used to

examine the barriers of accessing mental health services for USAF members found

in the literature review. Chapter IV addresses the research design, sampling and

data collection procedures, data collection instrument, and statistical analysis.

Chapter V presents statistical results of this research and offers an analysis of

comments written by survey respondents. Finally, Chapter VI summarizes the

findings and makes recommendations for policy changes in the USAF, as well as

suggestions for future research.

Definitions of Concepts Explored

The most common term used in this dissertation is "help seeking." Help-seeking behavior in relation to mental health problems is separated into two categories: (a) formal and (b) informal (Gourash, 1978; Veroff et al., 1981). Formal help seeking is defined as obtaining the services of a trained mental health professional, including social workers, psychiatrists, psychologists, or counselors. Informal help seeking involves pursuing assistance from others, including friends, family, and clergy. Physicians are often placed in either category, making the distinction less clear. For this dissertation, help seeking is equivalent with formal help seeking (defined above).

"Barriers to accessing mental health services" is another key term used in this dissertation. Webster defined barriers as "an outer defense to impede or stop an enemy" (Gove, 1986, p. 179), whereas in this dissertation barrier is equivalent with impediment or difficulty. Therefore, the phrase "barriers to mental health services" is synonymous with impediments to accessing mental health services or difficulties in obtaining mental health services. The term "mental health services" includes counseling in individual and group settings with a trained mental health professional. In order to avoid confusion, data from inpatient mental health services were not used because of considerable overlap between inpatient and outpatient mental health treatment (Fellin, 1996). The term "mental health problem" is any problem in which a mental health professional delivers the

primary intervention. Under this definition many problems are considered mental health concerns but may involve other services. For example, domestic violence is considered a mental health problem, with the legal system possibly being involved; that is, the primary mode of intervention is not incarceration but counseling. Because this research involved "active-duty USAF members," this term is also defined. Active-duty USAF members are men and women who work daily in the USAF. Unlike members of the guard or reserve, active-duty USAF members receive full medical coverage through the military.

CHAPTER II

LITERATURE REVIEW

In this section, mental health problems, service utilization, and barriers to accessing mental health services among members of the general population are explored. After this analysis, these same areas are examined among USAF members and then a comparison between the two populations is made.

The sources used for this chapter and Chapter III were varied. Studies conducted on USAF personnel only were available, but studies with members of the army, navy, and marine corps also helped to inform the present investigation. References to "the military" include members of all branches of the military. The generalizability of the results of studies conducted with other branches of the armed forces to the USAF may be questionable. Therefore, literature focused on USAF personnel has been emphasized. Literature using members of the other branches was used sparingly and cautiously.

Mental Health Problems in the General Population

Mental health problems in the general population of the United States are significant. In 1980, the National Institute of Mental Health sponsored the Epidemiological Catchment Area study of 19,182 people in five U.S. cities to evaluate the prevalence of psychiatric disorders in America. This study consisted

of two evaluations made 1 year apart. During the first year of the study, researchers concluded that 20% of Americans experience clinically significant mental disorders during the course of 1 year. A subsequent study 1 year later found that 28.1% of these subjects had mental and addictive disorders. The Epidemiological Catchment Area studies had limitations (Fellin, 1996). Dohrenwend and colleagues (1980) concluded that substantial numbers of people have significant mental health problems. Neugebauer and colleagues (1980), for example, found that 21% of the general population had significant symptoms of distress compared to clinical populations.

The prevalence of chronic mental illness in the military is very low (McCarroll, Orman, & Lundy, 1993a). Instead, the more common mental health problems are represented in suicides, alcohol abuse, and posttraumatic stress disorder. In the general population, the prevalence of these problems has been examined. Since 1980, the suicide rate in America has remained relatively steady at approximately 11 per 100,000 (U.S. Bureau of the Census, 1996). The use of alcohol in the general population has declined modestly during the last 2 decades. The U.S. Bureau of the Census reported that approximately 25% of adults use alcohol per month. The prevalence of people with a diagnosis of alcohol dependence is about 14% (American Psychiatric Association, 1994). The prevalence of these other problems seems fairly well-established. Assessments on the prevalence of posttraumatic stress disorder are widely varied, with estimates ranging from 1% to 14% of the population suffering from this disorder (American

Psychiatric Association, 1994).

Mental health problems have been defined to include problems such as domestic violence, with the prevalence of this problem in the general population also included. The number of child abuse cases was 1,197,133 in 1994, which is an increase of more than 50% since 1990. Straus, Gelles, and Steinmatz (1980) found that 3.6% of children from 3 to 17 years old are exposed to abusive violent acts each year. Definitional problems account for great variability in child abuse rates, with the weight of evidence showing a very high prevalence of child abuse (Haguuard, 1992). Establishing rates of spouse abuse is even more problematic. In 1985, the National Family Violence Resurvey found that 161 out of 1,000 women experienced violence in their relationships (Bachman & Pillemer, 1992). In other words, 16% of women experience a violent episode with their male partners each year. Overall, the general population appears to have substantial mental health needs. Unfortunately, many do not access mental health services.

Mental Health Services Utilization

Olfson and Pincus (1994a) evaluated several studies of mental health utilization. The Epidemiological Catchment Area study concluded that 10.7% of the general population use outpatient mental health services during a 1-year period. The 1980 National Medical Care Utilization and Expenditure Study, however, found that only 4.4% use mental health services. Olfson and Pincus's evaluation of the 1987 National Medical Expenditure Survey found that 3.1% of 38,446 respondents used psychotherapy during a 12-month period. The relatively wide

range in these statistics may stem from various definitions used in the studies. The Epidemiological Catchment Area study used a broad category for mental health services, and, as a result, more than half of these services were provided by general medical practitioners. The last study, however, focused exclusively on psychotherapy of which mental health providers conducted more than 90% of the visits. From the results of these three studies, between 3% to 6% of the general population seek the services of a mental health provider during a 1-year period (Olfson & Pincus, 1994a).

When comparing these rates with those of mental health problems, a significant number of people with mental health problems obviously never see a mental health professional. Link and Dohrenwend (1980) found that among significantly distressed individuals only 27% receive mental health services; they also believed that this number was inflated. Fellin (1996) indicated a rate at approximately 20%. The national comorbidity study reported that only 40% of people with lifetime mental disorders receive professional help (Fellin, 1996).

Barriers to Accessing Mental Health Services

Reasons for the low utilization of mental health services are varied. The literature contains considerable overlap, with social workers tending to focus on the economic, geographic, and cultural barriers to accessing help. Whereas psychologists and others have examined differences among groups and individuals. Regardless of the perspective, however, barriers to accessing mental health services present both policy and practice challenges.

Economic Barriers

One of the most significant barriers to accessing mental health services is the financial cost (Fortney, Booth, Blow, Bunn, & Cook, 1995; Meyerson & Herman, 1987; Runyan & Faria, 1992). Many people cannot afford mental health services. American political leaders have been hesitant to spend money on social programs for the mentally ill. As a result, services for the mentally ill are usually uncoordinated and haphazard, with emergency rooms serving as the main portal of entry for the chronically mentally ill (Meyerson & Herman, 1987).

Knesper et al. (1985) pointed out that the irony of mental health services in the United States is that people most in need are often unable to work because of their mental illness. Because they are unable to work, they are unable to afford many services and, therefore, must rely upon community support. People who are better off financially can afford mental health services, which they often do not need. The chronically mentally ill go underserved, even though there are many well-educated and highly trained providers receiving a lot of money to talk with people who have only mild emotional problems (Knesper et al., 1985).

Feinson and Popper (1995) challenged the importance of affordability and the use of mental health services. They compared rates of utilization for Americans who pay for mental health services directly with Israelis who have state-funded mental health coverage for all. They examined two large-scale studies of mental health services in each country. The results showed that Americans were consistently more likely to use mental health services than Israelis in all age

groups. In fact, the utilization of mental health services for older adults was 40% higher for Americans. This study, however, had several limitations, most notably the absence of any cultural analysis. Namely, are there cultural barriers that might prevent Israelis from seeking help? Still, these results seem to confirm the observation of Snowden, Collinge, and Runkle (1982); that is, even when financial factors are eliminated, many people still do not seek help. Therefore, other factors must also influence the decision.

Geographic Barriers

The "geographic approach" to explaining help-seeking behavior posits that the distance from mental health services is directly related to utilization of those services (Snowden et al., 1982). Some evidence dismisses this factor. Two large-scale studies, however, support the impact of the geographic approach.

Fortney et al. (1995) studied the outpatient appointment behavior of 4,621 male veterans discharged from an inpatient alcohol rehabilitation center. A logistical regression analysis revealed that the farther patients lived from the treatment facility, the less likely they were to make outpatient appointments. These results contradicted previous research with private health care clients; thus, Fortney et al. speculated that travel costs may be the discriminating factor with users of public facilities.

Sommers (1989) examined the relationship between geographic locations and utilization with 1,053 clients from a community support program. Even when controlling for accessibility, availability, sociodemographic, and need factors, the

farther clients lived from mental health services, the less likely they were to use them.

Cultural Barriers

Culture also plays an important part in the decision to seek help. The literature contains numerous articles examining help-seeking behaviors of several ethnic groups. In general, this literature indicates that Anglo Americans use mental health services the most (Olfson & Pincus, 1994b), African Americans more than expected (Broman, 1987; Cheung & Snowden, 1990), and Asian and Pacific Islander Americans the least (Cheung & Snowden, 1990). Native Americans have varied rates, in part, because of cultural distrust of the Anglo American culture (Rodenhauser, 1994). This factor is explored further in the section on demographic characteristics of help seekers.

Confidentiality Concerns

People seeking mental health services expect confidentiality. Several studies have shown that between 60% to 95% of clients would be concerned if others saw their mental health records or knew what they shared in therapy (Howe, 1989). Lindenthal and Thomas (1982) found 22% of the clients in their study avoided therapy because they feared a lack of confidentiality.

Confidentiality appears to be an essential component of mental health services. All major mental health professions contain guidelines concerning protecting client confidentiality. The social work code of ethics states, "Social

workers should protect the confidentiality of all information obtained in the course of professional services, except for compelling professional reasons" (National Association of Social Workers, 1996b, p. 10). Confidentiality is essential because therapy is meant to provide an atmosphere of trust (Davidson & Davidson, 1995); without trust, clients may be unwilling to disclose information essential to successful treatment. Lazarus (1978) countered that some people use the lack of confidentiality to avoid involvement in treatment. Regardless, without the assurance of confidentiality, some clients will avoid seeking mental health services.

Serious threats to client confidentiality have emerged with the increasing reliance upon managed care and insurance companies to provide mental health care. Davidson and Davidson (1995) found that these companies compile databases of people and problems in order to control costs and to make money. In order to cooperate with these companies, social workers often divulge sensitive information. Clients usually give permission for this information to be released, but they are often unaware of the nature or use of the disclosed information. Davidson and Davidson (1996) charged that this information is often stored in unprotected databases, used in questionable research protocols, and generally made available to other third parties. Despite laws and codes that protect confidentiality, threats to confidentiality do exist, and they do constitute a significant barrier.

Negative Beliefs About Mental Health Problems and Services

People with mental health problems are one of the most stigmatized groups in the United States (Minkoff, 1987). Veroff et al. (1981) found that 13% of their sample would never seek mental health services and that another 35% resisted the idea that they would ever need to seek professional mental health care.

Likewise, the stigma associated with mental illness is pervasive. Fellin (1996) saw the media as one cause of this stigmatization. He found that few chronically mentally ill ever pose a danger, but the widespread portrayal of the mentally ill is that they are dangerous or freakish. Despite efforts to change perceptions of mental health problems, the stigma remains (Farina, Fisher, Getter, & Fischer, 1978).

Mental health providers are also viewed negatively. Veroff et al. (1981) found that the number of people seeking mental health services has increased, with a widespread distrust of science and mental health practitioners emerging. Fellin (1996) again cited examples from the media in which mental health professionals are often portrayed as lecherous or incompetent. Overall, the stigma associated with mental illness and the negative perception of mental health providers constitute a serious barrier to help seeking.

Conclusions

Mental health problems in the United States are widespread, but most people with these problems never access professional mental health services. A

variety of financial, social, and psychological barriers prevents this access. In the USAF, a similar pattern has emerged.

Mental Health Problems, Service Utilization, and Barriers to Accessing Mental Health Services in the U.S. Air Force

The U.S. military and social work have had a long relationship. Military social work is one of the oldest occupational social work professions, dating back to the Civil War and being officially recognized in 1943 (Garber & McNelis, 1995). The USAF initiated a social work program in 1952. Initially, this program provided social work support for mental health services but has expanded into other areas such as drug and alcohol rehabilitation, domestic violence prevention, and treatment programs (Garber & McNelis, 1995). Presently, the USAF employs more than 200 military social workers to serve almost 400,000 USAF men and women and their families.

Mental Health Problems Among U.S. Air Force Members

Social workers help USAF members with a variety of mental health needs. Because all potential military members must pass physical and some psychological tests, few with chronic mental health problems are accepted for service. Since the 1970s, the USAF has used a three-phrase mental health screening process to evaluate the appropriateness of recruits for the military, with approximately .25% being discharged because of current problems or significant psychiatric histories (Crawford & Fielder, 1991). In addition, USAF regulations prevent people with

chronic psychiatric disorders such as schizophrenia and bipolar disorder from remaining on active duty. As a result of these policies, few USAF members suffer from chronic mental health problems. In a study of 3,000 army clients, McCarroll et al. (1993a) provided further evidence for this conclusion, finding that more than 50% were diagnosed as phase of life or other life circumstance problems. Admitting other factors may account for this low number; however, they concluded that the population was healthy from established psychiatric health problems. The military, however, has substantial mental health needs—especially in the areas of suicide, domestic violence, alcohol abuse, and posttraumatic stress disorder.

Suicide

From 1980 to 1993, suicide was the third leading cause of death among military males and fourth among military females (Helmkamp & Kennedy, 1996). The rate of suicide among USAF members has been increasing. In 1990, the suicide rate in the USAF was 10.8 per 100,000. In 1995, the rate increased to 15.9 per 100,000 active-duty USAF members (J. Westover, USAF epidemiology systems consultant, electronic mail communication, June 3, 1997). The rate dropped to 12.4 in 1996 but remains higher than the general population rate (J. Westover, USAF epidemiology systems consultant, electronic mail communication, June 3, 1997).

From 1980 to 1992, suicide rates among all branches of the U.S. military increased dramatically, comprising 12% of military fatalities (Helmkamp, 1995). The highest rates occurred among enlisted men between 17 and 24 years old. The

suicide rate for officers was half the rate of enlisted personnel, with Anglo

Americans having a disproportionate number of suicides (83%). Men accounted

for 95% of suicides, with firearms the preferred method. Women constituted very

few suicides, but their rate was as high as 9.1 per 100,000. Overall, Helmkamp

found a 16% increase in suicide rates during the 13 years studied. His

methodology relied upon statistics from the Department of Defense and National

Center for Health Statistics, involving a retrospective study of cases identified as

suicides. One problem with this type of analysis is that suicide rates, in general,

are considered to be underreported (Holding & Barraclough, 1978). For example,

self-inflicted wounds often are labeled accidental unless clear evidence of suicidal

intent is uncovered (Kawahara & Palinkas, 1991). Other researchers (Eggertsen &

Goldstein, 1968) have argued that military suicides might be underreported.

The rate of suicide among military members has been reported to be from

15% to 20% lower than the national average (Helmkamp, 1995). Kawahara and

Palinkas (1991) attributed the lower rate to the availability of mental health

services, formal and informal screening, and the military culture. Therefore, the

sudden increase in suicides remains unexplained, needs further investigation, and

indicates a substantial mental health need among USAF members.

Domestic Violence/Marital Discord

Domestic violence is one of the most researched and controversial topics in

the military. Since 1981, all branches of the military have adopted programs to

deal with domestic violence. According to officials of the Department of Defense

(L. Besetsny, research psychologist, family advocacy program, electronic mail communication, May 5, 1997; Jowers, 1996b), despite these efforts the rate of spouse abuse has increased during the last 2 years. In 1995, 14.3 per 1,000 USAF spouses were abused. The rate of child abuse, however, has dropped to 6.6 per 1,000 USAF children. The actual rate may be even higher because (a) military spouses often do not report domestic violence fearing for their spouses' careers (Coolbaugh, 1994a, 1994b) and (b) medical personnel have a poor understanding of domestic violence and treatment options (Hamlin, Donneworth, & Georgoulakis, 1991).

Mollerstrom, Patchner, and Milner (1992) conducted extensive research into domestic violence among USAF members. They analyzed 1,454 abuse cases during a 1-year period, finding 74.6% involved physical abuse of a spouse or child. Physical abuse of a spouse made up 50% of all cases. Most cases, however, were low in severity, with less than 6% being severe. Women represented three fourths of the spouse abuse cases, with child abuse cases being split evenly between boys and girls. The Mollerstrom and colleagues evaluation appeared thorough, but it had potential problems. They relied upon the evaluations of family advocacy officers who used standardized forms to access abusers. The forms were complicated. These officers often chose between categories when another category was needed. They also rarely received adequate training in using the forms; therefore, the accuracy and consistency of their assessment were questionable. Still, the research of Mollerstrom and colleagues indicates that

spouse abuse is a problem in the USAF.

Hulbert, Whittaker, and Munoz (1991) conducted evaluations of a sample of abusive military husbands, finding that they had higher incidences of alcohol abuse, more rigid attitudes toward women, lower marital satisfaction, and considered their wives to be less attractive than nonabusive husbands. This study included 30 abusive and 30 nonabusive husbands, using a variety of reliable measures. The study had several shortcomings, including distinctive differences in the demographic characteristics of the two groups. The study also failed to analyze the effect of being in the military on the attitudes and beliefs of the participants.

Overall, domestic violence is a serious problem in the USAF, with spouse abuse increasing despite the availability of professional help. Hulbert and colleagues (1991) also suggested that USAF military members may have personalities that may promote domestic violence.

Substance Abuse

Drug and alcohol abuse is another area in which the military has devoted extensive resources. During the 1970s, use of illicit drugs became increasingly problematic for the military. As a result of random drug testing and punishing and discharging drug users, the military has dramatically decreased illicit drug use (Bray et al., 1992). From a series of military surveys, Bray et al. (1992) found that the number of military members who used illicit drugs during a 30-day period declined from 27.6% in 1980 to 3.4% in 1992. The rate of 3.4% is considerably lower than the rate of 9.8% among civilians. Alcohol use and abuse among

military members, however, remains problematic. Overall, Bray and colleagues found that military personnel were more likely than civilians to be heavy drinkers and that military men between the ages of 18 and 25 were twice as likely to be heavy drinkers as civilians. More than 15% of the military personnel were considered to be heavy drinkers (defined as weekly, drinking five or more alcoholic beverages during a drinking event). The USAF rate was lower at 10.7%, decreasing significantly since 1980.

The Bray et al. (1992) survey was an impressive piece of research. They selected 25,000 military members of all ranks, services, professions, and ethnicities from 63 locations throughout the world. They received 16,395 usable returns, with the USAF response rate at more than 95%. This survey was extensive; however, it also had several potential problems, which Bray and colleagues discussed. They noted, for example that military members may have given socially desirable answers to questions rather than truthful ones because they feared negative repercussions. In fact, an analysis of alcohol sales in USAF stores showed that alcohol use may have been underestimated by as much as 20%. The finding of decreased drug use, however, was consistent with decreases in positive urinalysis results.

Stout, Parkinson, and Wolfe (1993) provided further evidence that alcohol use is problematic in the USAF. In a retrospective study of alcohol-related mortality, they analyzed the deaths of 283 USAF members who died in 1990. They found that 66 or 23% were alcohol related, with most involving young Anglo

American men under the age of 21. Stout and colleagues noted one problem with the research, that is, the software package—Alcohol-Related Disease Impact (ARDI) program. This program has been shown to underestimate alcohol-related deaths. Another problem not mentioned was that they considered blood-alcohol levels as low as .02 to be contributing factors in the studied deaths; in fact, some of the deaths may have occurred regardless of alcohol use. Another problem was reliance upon death certificates, which were assumed to be accurate. This evidence still seems to support the claim of Bray et al. (1992); that is, members of the USAF are much more likely to drink and drink heavily than their civilian counterparts (Stout et al., 1993).

The literature shows that heavy alcohol consumption in the USAF represents a substantial mental health need. Military members who drink heavily are also more likely to engage in other dangerous behaviors such as smoking and driving under the influence of alcohol (Fertig & Allen, 1996). The reasons for alcohol abuse are varied and debated. One reason germane to this discussion is that USAF members may drink heavily in order to cope with distress rather than to seek help from a mental health professional (Wills & Shiffman, 1985).

Posttraumatic Stress Disorder

The primary activity of the military is combat (Wood, 1982). The effect of combat on soldiers is one of the most studied and debated topics among mental health professionals (Aldwin, Levenson, & Spiro, 1994; Fontana & Rosenheck, 1994; Pierson & Pierson, 1994; Van Wormer, 1994; Weaver & Stewart, 1988).

The effects of combat have been observed throughout history (Weaver & Stewart, 1988), but it was not until World War I that serious inquiry began. Physicians noticing a far-off lost look and malaise in soldiers who had spent long periods of time at the front called the condition "shell shocked," believing it was a brain condition brought on by the constant vibration of exploding shells. In World War II, the same symptoms were identified as a psychological disorder; the condition was relabeled "combat fatigue." The Vietnam War provided the impetus for further investigation of mental health problems related to war that today are commonly termed "posttraumatic stress disorder" and "combat stress reaction" (Weaver & Stewart, 1988). Regardless of the name given to the disorder, mental health problems related to war have accounted for 10% to 50% of wartime casualties (Armfield, 1994).

Studies of veterans from World War II, the Korean War, and the Vietnam War clearly show that exposure to combat is related to the development of posttraumatic stress disorder (Fontana & Rosenheck, 1994). A 1988 congressional study of 479,000 Vietnam veterans found that approximately 15% suffered from the disorder (Kulka et al., 1990). Stretch et al. (1996) reported that soldiers deployed to the Persian Gulf during Operation Desert Storm experienced significantly higher amounts of stress than soldiers not deployed and civilians. The researchers predicted higher incidences of posttraumatic stress disorder among deployed soldiers. Their comprehensive study relied on the self-report of more than 4,000 soldiers who returned mailed inquiries. The self-selection process,

combined with the potential for soldiers to give socially appropriate responses, may have compromised the study. In addition, demographic differences between the groups may have contributed to the findings. Still, if past wars are indicative, many veterans of Operation Desert Storm will suffer from posttraumatic stress disorder.

The literature shows that war-related duties have and will continue to have an adverse effect on the mental well-being of soldiers despite shortcomings and disagreements. In addition, combat-related problems such as posttraumatic stress disorder are comorbid conditions with other mental health problems, including alcohol abuse and depression (Hryvniak & Rosse, 1989).

Mental Health Services Utilization

Many programs and services to assist USAF members with these problems are available. For example, active-duty USAF members have access to professional mental health services free of charge.

Each USAF base has an extensive substance abuse prevention and control program. Under Air Force Instruction (AFI) 36-810, all USAF members are required to attend substance abuse awareness training upon arriving at their first duty station. In fact, Bray and colleagues (1992) found that more than half of USAF members surveyed had attended alcohol and drug education. Substance abuse control also offers a variety of treatment programs. All USAF members found using illicit drugs are discharged. Those identified with alcohol problems are given education or inpatient/outpatient treatment. According to Bray and

associates, more than 7% of USAF members have participated in an alcohol treatment program.

The USAF family advocacy program (described in AFI 40-301) is designed to prevent family violence. When violence occurs, the family advocacy program provides or refers services for the victims and perpetrators. This program is also available to all USAF members. Problems associated with combat and other stress-related conditions are treated through mental health services.

In order to combat the recent increase in suicides, the USAF has instituted "suicide prevention education and community training." This program (mandated by AFI 44-154) requires community-level training of all USAF personnel. This training educates USAF members on risk-factor awareness and referral procedures. More importantly, the regulation states, "The purpose of this program is to equip squadron supervisory personnel to act as gatekeepers, lowering the barriers to self-referral and de-stigmatizing help-seeking behavior through changing the corporate culture" (p. 1). Since this program has only recently been implemented, it is too early to evaluate its effectiveness.

In examining the utilization of mental health services among military members, Bray et al. (1992) found that 6.4% had received mental health counseling services during the previous 12 months; for the USAF, the average was 7%. In addition, 1.5% had received substance abuse counseling or treatment. Of the 1,537 military members who had been hospitalized during the previous 12 months, more than 9% had received psychiatric or substance abuse treatment or

both. The USAF members in this sample had similar inpatient mental health treatment rates.

Overall, the utilization rate of mental health services among USAF members appears to be consistent with rates among civilians (6% to 7% per year), although direct comparisons are difficult because of differences in definitions of mental health services between studies. This finding alone suggests that USAF members are underutilizing available services. Further analysis, however, suggests that USAF members may use mental health services even less than civilians.

One reason the rate may be substantially lower is that one third of those seeking USAF mental health services have been ordered to undergo mental health evaluations (Crosby & Hall, 1992; Rowan, 1996), whereas another third may have been influenced by a superior (Rowan, 1996). In a retrospective study of 693 records belonging primarily to USAF members, Rowan found that approximately two thirds of the referrals to mental health services involved the recommendation of a military authority figure or a mandate from a commander. Among unmarried military members 82% of the referrals fell into this category. In a similar study, Crosby and Hall (1992) found that one third of referrals were command directed. Since extensive documentation must accompany all command-directed evaluations (Department of Defense, 1993), a review of mental health records should have been an accurate way to measure the number of USAF members ordered for evaluations in both of these studies. Interpreting the influence of supervisors on referrals is more problematic. Other branches of the military, however, have

similar referral patterns. McCarroll, Orman, and Lundy's (1993b) study of primarily army personnel showed that approximately 40% were referred by supervisors, whereas Bailey's (1980) study of sailors showed that only 22% to 38% were self-referred.

In addition, two factors that keep civilian help-seeking rates low are not present in the USAF. The financial barrier to seeking mental health services is not a factor in the USAF because they are free. In addition, since mental health services typically are located near (within a few miles) work areas of USAF members, the geographic barrier is minimized. Because one third to two thirds of USAF help seekers are ordered or influenced by a superior to seek mental health services and the most significant barriers to mental health services are absent in the USAF, other factors must be preventing USAF members from seeking mental health services.

Barriers to Accessing Mental Health Services

Many of the barriers that prevent USAF members from accessing mental health services are factors in the civilian community. Other factors, however, appear unique to the military and the USAF. No study has exclusively examined barriers to accessing mental health services in the USAF; however, several researchers have examined patterns of help seeking in the USAF and have drawn conclusions. Rowan (1996) examined the relationship between job status, case disposition, and help seeking. He found that military members with special-duty assignments were less likely to self-refer for treatment than people in other

categories. Special-duty assignments involve USAF members with special security clearances or those who carry weapons. AFI 31-501 states that if mental or emotional illness threatens a person's judgment his or her access to classified materials can be revoked. Rowan also found a positive correlation between rank and self-referral; that is, higher-ranking members were more likely to self-refer. Higher-ranking members, however, were also the least likely to seek services since they comprised only 6% of the sample. Fear of negative career impact among these categories may explain low help-seeking rates. Unfortunately, this study did not directly examine factors that contribute to the decision to seek help. In fact, one of Rowan's recommendations was to study the impact of factors such as the stigma associated with seeking help and negative career impacts.

Bray and colleagues (1992) examined military members' reasons to avoid seeking treatment for alcohol problems. They found that approximately 60% of military members believed that seeking help for an alcohol problem would result in disciplinary action. They also believed that their commanders would find out (43%) and that it would damage their careers (36%). The results were similar for USAF members, except 43% believed seeking help for alcohol problems would hurt their careers. Unfortunately, this study examined barriers to help seeking only with regard to alcohol abuse.

Bowen (1985) conducted a qualitative study of 664 USAF married couples to access knowledge of services and barriers to help seeking. He found that couples were much more likely to participate in educationally oriented classes such

as marriage enrichment than marriage counseling with a mental health professional. Still, more than 60% stated that they were "somewhat likely" to seek professional help if they experienced relational difficulties. Bowen, however, found that the stigma attached to help seeking in the military and the lack of confidentiality afforded in military mental health settings resulted in USAF couples preferring to seek help from civilian sources. Bowen's study provided evidence for barriers to help seeking, focusing primarily on programs and services but not mental health services.

Coolbaugh's (1994a) qualitative study of domestic violence in the military offered a more thorough evaluation of barriers to help seeking. Coolbaugh conducted focus groups with abused spouses of military members. From her analysis of comments of 100 spouses, Coolbaugh found that victims of domestic violence were reluctant to report abuse because they were afraid that their spouses' careers would be adversely affected and that the military offered little confidentiality. Their abusers often told them that if they reported an abusive incident they would be left financially devastated. The spouses also stated that they did not trust the military to help them. Unfortunately, this study was conducted with spouses of active-duty members—not the members themselves. Still, spouses' perceptions of barriers may be closely linked to their active-duty partners, but this conclusion is speculative.

Despite few empirical studies on the subject, military mental health professionals and others agree that barriers to accessing military mental health

services exist and are well-known. In June 1996, The Air Force Times featured a cover story entitled "Getting Help: Where To Turn in a Time of Crisis—Will Admitting A Problem Hurt Your Career?" (Jordan, 1996). One month later, The Army Times contained a similar story entitled "The Stigma of Seeking Psychological Help." Both stories contained extensive interviews with military mental health professionals and their opinions about military mental health services and barriers to accessing care. Overall, these articles supported the notion that military members who seek mental health services are stigmatized (Galvin, 1996; Jordan, 1996; Jowers, 1996b).

One of those interviewed was Peter McNelis (Jowers, 1996b), a retired military social worker and director of the Military Family Institute at Marywood College in Pennsylvania. He stated that military members are culturally resistant to seeking mental health services. Kutz (1996) argued that the military culture is like other minority cultures that "places great stigma on mental illness" (p. 80). Both McNelis and Kutz also acknowledged that a person's career in certain jobs could be jeopardized by seeking therapy. For example, military pilots cannot fly for 1 year after taking an antidepressant (Porter & Johnson, 1994). Mark Waple, an attorney who has handled several cases involving military members and the mental health system, stated that the lack of confidentiality is one of the greatest hindrances to seeking help (Galvin, 1996).

Evidence exists that supports and challenges the accuracy of these perceptual and attitudinal barriers. Literature from social work, sociology,

medicine, and psychology assists in understanding the barriers that hinder USAF members from seeking mental health services.

Fear of Negative Career Impact for Seeking Help

General Ronald D. Fogelman, former USAF chief of staff, has repeatedly stated that anyone who "honestly" needs help will not be hurt by seeking help (Jordan, 1996). Military mental health professionals also deny that seeking help hurts members' careers. Col. Harry Howitz, USAF clinical psychologist, stated that it is the problems created by not seeking help that ruin careers (Jowers, 1996a). T. Hardaway, army medical command child psychiatry consultant, added, "It's not the seeking of the mental health services that gets in the way of a career, it's the behavior that leads to the problem" (Jowers, 1996a, p. 14).

Rowan (1996) characterized as "myth" the idea that seeking help has a negative impact on careers. His research, however, showed that 10% of people who seek help are recommended for discharge by a mental health provider. Another 4% were recommended for a change in career, and 13% were placed in mandated treatment. Further analysis, though, showed that few people who sought help on their own fell into these three categories. Of the 693 records reviewed, only 4 self-referred clients were recommended for discharge, 2 for career change, and 3 for mandatory treatment (representing only 1% of those who sought help on their own). Other repercussions were not studied. Whether or not these people were discriminated against at their workplace was unknown.

Crosby and Hall (1992) analyzed differences between airmen who self-referred for psychological help and those directed by commanders. Researchers used chi-square analyses to look for differences between these groups in terms of problems, diagnosis, disposition, and treatment. They found that those directed for evaluation were more likely to have occupational problems and to be diagnosed with an Axis II disorder. Axis II disorders are developmental or personality disorders (American Psychiatric Association, 1994). These diagnoses are not grounds for separation by themselves; however, people with these disorders may experience work difficulties. Those ordered for evaluations by their commanders were more likely to be recommended for job limitations and less likely to continue in treatment beyond their evaluations. One limitation of the Crosby and Hall study was that they did not distinguish between those who might have been unofficially coerced into seeking help and did not examine the long-term effects of having sought professional mental health care.

McCarroll and colleagues (1993b) contradicted the findings of others. They found that supervisor-referred clients received less severe diagnoses than those who self-referred. Their study, however, which consisted of 1,835 clients, drew primarily from army populations, which may account for some differences. In addition, how the 16 clinicians who evaluated the clients were trained for the study is unclear.

Coolbaugh (1994b) found some evidence to support that involvement with mental health services hurts a military member's career. From the military central

registry, Coolbaugh studied 3,492 substantiated child and spouse abuse cases from 1988 to 1990 that involved active-duty USAF members. Coolbaugh found that abusers were more likely to be separated from the USAF than matched control subjects and that they were also more likely to be discharged under less than honorable conditions. Among middle-grade enlisted members and officers, abusers were also less likely to have been promoted than matched control subjects.

These numbers appear to make a strong case that being involved in domestic violence subsequently hurts careers. This conclusion is misleading for several reasons. First, some people involved in domestic violence would suffer negative consequences whether or not they were in the military. For example, those involved in sexual abuse, a subcategory of domestic violence, are likely to be criminally prosecuted or otherwise sanctioned in both the civilian and military communities. In the USAF, 74% of officers identified as sexual abusers were separated. Another reason Coolbaugh's (1994b) findings were misleading is that people who commit domestic violence may be predisposed to have other problems in the military. Batterers often suffer from low frustration tolerance, obsessive/compulsive traits, immaturity, and pathological jealousy (Deschner, 1984). These same traits may lead to other problems in the military.

An examination of these studies reveals three distinct findings. First, involvement with mental health services can influence or disrupt a USAF member's career, but this represents only a small portion of those seeking help. Second, long-term repercussions are generally unknown; that is, people who self-

refer for mental health services rarely suffer immediate repercussions. Finally, the perception of the repercussions of seeking help appears disproportionate to the evidence. As Bailey (1980) found in a study of 1,952 navy members, 50% believed they might be discharged as a result of their involvement with mental health services. Unfortunately, none of these studies adequately addressed the relationship between these findings and help seeking; in fact, any conclusions are somewhat speculative.

Confidentiality Concerns

Confidentiality is a barrier to accessing mental health services in both the civilian and military communities. Both communities have safeguards, but they also have threats to confidentiality. Reed (1996), chief of the military justice division in the USAF judge advocate general's office, stated that the Federal Privacy Act ensures that military medical records are protected. Under this act, third parties cannot routinely view these records without a client's permission, but officials are allowed to access the records for limited and official uses. Official uses can be anything from security clearances to criminal investigations. Members' records often are reviewed without their knowledge. Mental health records are kept separate from general medical records, but general medical records do contain entries documenting visits to mental health services. As a result, investigators are led to inquire about mental health visits.

Access to records is not the only way that confidentiality can be violated. Military mental health programs are designed to involve a client's commanders.

For example, the family advocacy program works with unit commanders to ensure compliance with treatment. Commanders usually are involved in referrals for substance abuse treatment and are entitled to know the results of mental health evaluations. Even for routine appointments, USAF members often take time off from work, which they must justify to their supervisors. Details of the visit are not disclosed; consequently, keeping the therapeutic visit confidential is difficult. The USAF is a close community, with others often knowing when someone is involved with mental health services. Ball and Gingras (1991) summed the relationship between confidentiality and the military, stating that despite safeguards military personnel sign away their rights to complete confidentiality upon enlistment. The army surgeon general consultant for psychology stated that for military psychologists confidentiality does not exist (Jeffrey, Rankin, & Jeffrey, 1992).

Another threat to confidentiality lies in the conflicting loyalties and obligations of military mental health professionals. Military mental health professionals have allegiances to their clients, as well as their sworn obligation to the military (Howe, 1989). Few empirical studies of this problem have been conducted. Jeffrey and colleagues (1992) analyzed the dilemmas raised by two case studies, showing that military regulations about confidentiality often conflict with ethical professional standards. As a result, one psychologist was found in compliance with military regulations but in violation of the ethics of the American Psychological Association; whereas another was in compliance with the

association's ethics but violated military mandates.

Another study highlights the conflicting loyalties of social workers that result in compromising confidentiality. Curtis and Lutkus (1985) conducted a study with 40 social workers who worked in police settings. Many of the issues raised in this study may be generalized to the military because military social workers may experience the same dilemma as police social workers. They both feel obligations to their employers and the clients, with these obligations sometimes competing. Curtis and Lutkus found that more than 70% of social workers working in a police setting had experienced some pressure from police to divulge confidential information. Surprisingly, approximately one third said they would not consider whether or not a client was homosexual, had a history of drug abuse, or had been raped to be "always confidential." Curtis and Lutkus also found that the longer social workers had worked with the police the more likely they were to divulge confidential information. They were also more likely to divulge information if the police paid their salary. Social workers in a police setting appear to have conflicting loyalties between their identified clients and the police. The longer these social workers were employed by the police the more loyalty they felt to their employers.

Unfortunately, the sample size in the Curtis and Lutkus (1985) study was too small for broad generalizations. Since the researchers used a mailed survey, participants were self-selected. This sampling technique may have introduced some response bias. The return rate was 58.6%. Information from those who did

not return surveys may have provided further and even different insights. Still, some generalizations may be warranted. Similar to the social workers in this study, military social workers have an obligation to serve the best interests of the military and the best interests of the client. These interests may be mutually exclusive. For example, if a client confesses that he is gay, the social worker may feel compelled to breach confidentiality out of loyalty to the service but also recognize the harm this action may cause the client.

Military and civilian social workers may have some issues in common, but there are also substantial differences. Military mental health professionals must be concerned about national security (Ball & Gingras, 1991). Considering that many military members have access to highly destructive weapons, including nuclear warheads, the mental health status of each military member is a concern of their leaders. Military members may be called to extremely difficult situations at any time, with military mental health professionals having to predict the future performance of past clients.

As a result of these conflicting loyalties and the issues of national security, it is easy to see how USAF members could perceive that the military offers little confidentiality. They may be unsure whether or not a mental health provider has more loyalty to them or to the military. Overall, the perception of limited confidentiality in military mental health settings is somewhat supported, but, again, no direct study of this factor as a barrier to help seeking has been conducted.

<u>Negative Beliefs About Mental Health</u>
<u>Problems and Services</u>

Another barrier to accessing mental health services may be a negative

perception of mental health problems and services. As discussed, this perception is

widespread in the civilian community. Since the military draws from the civilian

community, assuming that USAF members share this perception is reasonable.

The literature, however, contains research that both supports and refutes this

conclusion.

In a study of attitudes towards domestic violence and seeking help,

Coolbaugh (1994a) found that military commanders often knew about the family

advocacy program but believed that the qualifications of the staff were

questionable. The commanders stated that the family advocacy program staff were

often comprised of civilian women who did not understand or appreciate the

military. Senior-enlisted members believed that the staff often assumed the

accused was guilty and overreacted to allegations. Overall, they expressed both

praise and discontent, but they generally agreed that the family advocacy program

was necessary.

Rosen and Corcoran (1978) believed that most USAF mental health

professionals viewed line military officers as having "rigidly negative, authoritarian

attitudes toward the mentally ill" (p. 570). USAF line officers directly support

flying operations, whereas USAF mental health officers are mental health

professionals who work in support of hospital services. Rosen and Corcoran

analyzed the views of 455 USAF line officers and 40 USAF mental health officers,

examining differences in attitudes towards people with mental illness. They found that USAF line officers were "much more authoritarian in approach, viewed the mentally ill as a much greater threat to society, and were much less likely to view mental illness as an illness like any other" (p. 572). The line officers were also surprisingly benevolent towards the mentally ill to the point of being paternalistic. Except for their views of mental health problems as illnesses, the sample was remarkably close to civilian groups of similar age and educational background. The researchers concluded the perception that line military officers were uniquely insensitive and prejudiced against the mentally ill (Rosen & Corcoran, 1978).

More recently, Porter and Johnson (1994) conducted a similar survey of 137 navy and marine corps officers. They found that their sample consistently held more positive than neutral attitudes toward military members who sought mental health services. The sample believed that having sought mental health treatment should not impact promotion, but they also believed that they should know why a service member sought help.

The last two studies had several flaws. The most obvious, which none of the researchers addressed, was the impact of respondents giving socially desirable answers. This possibility may have been particularly problematic in the Porter and Johnson (1994) study because they utilized a simple self-made survey with questionable reliability and validity. In fact, 20% of the sample made negative comments about the survey. Rosen and Corcoran (1978), however, minimized the social desirability factor by using a standardized instrument that had been used in

numerous other studies.

Overall, a conclusion that negative perceptions of military mental health services and problems constitute a significant barrier is somewhat supported. Unfortunately, no studies of this specific factor with both USAF officers and enlisted members have been conducted.

Military Culture and Help Seeking

In the military, recruits are initiated into a new culture that demands they conform not only to overt rules and regulations but also to adopt a broad range of less obvious mores, beliefs, and values (Knox & Price, 1995; Kutz, 1996). Military members are driven to conform to the combat masculine warrior paradigm (Dunivin, 1994). Dunivin (1994) argued that this paradigm has been the traditional driving force behind the actions of soldiers for centuries.

The most obvious feature of the combat masculine warrior paradigm is the focus on masculinity. Some have even argued that masculinity and the military are practically interchangeable terms (Enloe, 1993). This masculinity entails a contempt for weakness and anything that associates the military with femininity (Warren & Cady, 1994). Since openness to personal weakness is a characteristic of someone willing to seek mental health services (Fischer & Turner, 1970), the military's contempt for weakness may hinder many members from seeking help. In addition, seeking psychological help also may be viewed primarily as a female activity since the majority of formal help seekers is women (Gourash, 1978; Veroff et al., 1981). Consequently, military members may avoid mental health services

because they see it as feminine.

Another value of the combat masculine warrior paradigm, which may be more peculiar to the USAF, is rugged individualism. Researchers have found that USAF pilots score high on the narcissistic factor of the Millon Clinical Multiaxial Inventory (Milgram, 1991) and that the typical image of a pilot is a young, attractive, rugged individualist (Frank, 1993). The results of the Millon Clinical Multiaxial Inventory may be questionable because it was designed for people with potential personality disorders (Millon & Davis, 1994); whereas the ideal of rugged individualism is common in American society—especially among men (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985). Rugged individualism is a trait that discourages seeking help for problems and would be an obvious hindrance to formal help seeking. Fischer, Grisso, Beck, and Winer (1972) found that the more people identified themselves as rugged individualists the less likely they were to seek formal help.

Overall, the literature suggests that the military culture plays a role in help seeking. This factor, however, has never been evaluated as a barrier; thus, conclusions about its effect must be very tentative.

Perceptions of the Availability of Services

Despite the wealth of mental health services available to military members, some studies indicate that a substantial number of military members may be unaware or misinformed concerning these services. For example, Bowen (1985) discovered that most of the couples in his study were aware of the available family

services, but many were not. Twenty-one percent of USAF husbands and 27% of USAF wives did not know that counseling for couples and families was available. Junior-enlisted couples were the least likely to know about the services. McCarroll et al. (1993b) found that 16% of self-referred clients did not seek mental health services earlier because they "didn't know where to go" (p. 707). Finally, Bailey (1980) discovered that among all types of referred clients only 11% expected outpatient treatment as a result of seeking mental health services.

Unfortunately, the assumption of military mental health providers is that everyone knows about their services (Bowen, 1985). This assumption may explain why few studies have examined the awareness of services among military members. These few studies, however, indicate that between 16% and 25% may be unaware of their mental health services options. Like other factors, however, knowledge of mental health services has not been studied as a barrier to help seeking.

Conclusions

The increasing amount of mental health problems among USAF members and the low rate of mental health services utilization seem to indicate that barriers to accessing mental health services exist. Some barriers can be identified from the literature, but they are generally poorly supported by the research.

CHAPTER III

DEMOGRAPHIC AND THEORETICAL PERSPECTIVES

OF HELP SEEKING

In this section, demographic characteristics of help seekers in the general population are explored and compared with the demographic profile of USAF members. Three theoretical perspectives of help seeking are also examined.

Demographic Characteristics of Help Seekers and U.S. Air Force Members

The demographic characteristics of help seekers have been studied extensively (Fellin, 1996; Olfson & Pincus, 1994a; Veroff et al., 1981). Demographic characteristics in themselves explain very little about help seeking, but they do indicate which groups are more likely to seek help. For this analysis, demographic findings of numerous studies of help seeking are compared with demographic data of USAF members obtained from Military Family Demographics: Profile of the Military Family (Military Family Resource Center, 1995).

Gender

Both men and women experience equal rates of mental illness, but women are more likely to seek mental health services (Veroff et al., 1981). Olfson and

Pincus (1994b) found that women were 50% more likely than men to seek and continue attending psychotherapy.

Since women tend to identify their problems more from a psychological perspective and are more open to discussing their problems, they naturally might be expected to visit mental health professionals more often (Horwitz, 1977, 1987). Men, on the other hand, are less likely to label their problems psychologically and are commonly coerced into seeking help. Women also are socialized to recognize emotional problems, seek help, and rely on internal self-control. Men, however, are conditioned to avoid talking about their problems and to expect external control for aberrant behavior (Horwitz, 1977, 1987).

The USAF has approximately a 6 to 1 ratio of men to women; therefore, the avoidance of help seeking may be partly explained by gender. Some military women may also avoid seeking help because they have adopted more androgynous or male sex role attributes (Marsden, 1991).

Age

Age is one of the most significant factors associated with help seeking in the general population (Horwitz, 1987). Horwitz concluded that the trend for help seeking peaks between the ages of 25 and 45 and then sharply declines. Olfson and Pincus (1994b) found rates of help seeking between 18 to 34 year olds and 35 to 45 year olds about the same. Since 81% of the military are 35 years of age or younger compared to 43% of the civilian community, help-seeking rates should be higher; thus, age appears to be a poor predictor of help seeking in the military.

Education, Socioeconomic Status, and Social Class

Researchers have drawn different conclusions about the impact of education, socioeconomic status, and social class on help-seeking behavior. Horwitz (1987) found that the higher people's education level and social class the more likely they were to seek formal help, with rates of mental illness inversely related to socioeconomic status. The reason behind this finding is the same as that for the conclusions of gender and age. Higher-educated and social-class people tend to attribute psychological causes to interpersonal and emotional disturbances (Horwitz, 1987). Veroff et al. (1981) found that education more than income was strongly positively correlated with help seeking. Gourash (1978), however, found little if any association between socioeconomic factors and help seeking. Veroff et al. and Horwitz had different conclusions from Gourash; they believed that these factors were becoming less important in predicting help seeking. The more recent research of Olfson and Pincus (1994b), however, clearly showed that middle- and high-income people are three times more likely to visit a psychotherapist once or twice than low-income people. Those with some college education, however, were more likely to seek psychotherapy than those with only high school diplomas or graduate degrees.

Applying these findings is difficult because USAF members come from a variety of backgrounds and education levels. Most USAF officers have graduate degrees (excluding those new to the USAF). Overall, 38% have advanced degrees beyond the bachelor's level. Historically, officers have been considered middle to

upper social class (Janowitz, 1960). USAF enlisted members, who outnumber officers four to one, are usually less educated than officers (3% with college degrees) and may be considered in a lower class. Because the role of education and income in help seeking is unclear, this factor may be a poor predictor of help seeking among USAF members.

Marital Status

Married people have low rates of help seeking (Horwitz, 1987) and appear to rely on each other for support, that is, men relying on women more than women relying on men (Veroff et al., 1981). Veroff et al. found that separated or divorced men and women were the most likely to seek help. They speculated that divorce and separation reduce people's social network and, as a result, drive them to seek mental health services. Unmarried people's help-seeking behavior is less clear than other categories, with reviewers reaching different conclusions (Horwitz, 1987; Wills, 1987).

More than 65% of USAF members are married, which is more than any other service. For senior officers and enlisted members, approximately 90% are married. Among junior enlisted members about half are married; this rate is higher than for any other branch of the military. As a result of the high marriage rates and when confronted with problems or distress, many USAF members probably seek informal help from their spouses rather than seeking professional counsel.

Single USAF members also may seek informal help from friends in the service rather than seeking professional help. Unlike the civilian community, young, enlisted members often live in dormitories similar to college students. Because of the stigma and fear of confronting painful issues, college students are often resistant to seeking psychotherapy (Haglin, Weaver, & Donaldson, 1985).

Ethnicity, Race, and Family Structure

Ethnicity, race, and family structure are integrally linked and assumed to be essential ingredients in the decision to seek mental health services. Unfortunately, the evidence surrounding the role of these factors is unclear. Barker and Adelman (1994) concluded that most research on help seeking in minority populations focuses on the underutilization of services, with African Americans using it the most and Hispanic Americans[1] and Native Americans the least. In general, ethnic minorities have been considered underserved by mental health professionals.

Some cultures are resistant to seeking help outside the family, whereas others are not. For example, many Asian cultures view seeking mental health services as shameful (Hepworth & Larsen, 1990; Narikiyo & Kameoka, 1992). Jewish Americans commonly use mental health services (Veroff et al., 1981). Broman (1987) concluded that the help-seeking behavior of African Americans was not well-understood, with many researchers finding contrary results. Broman

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[1]Hispanic is the designation that the Air Force Personnel Center applies to a broad spectrum of people whose ethnic origin began in places such as Central and South America, Puerto Rico, Mexico, and Spain.

found that African Americans were more likely than Anglo Americans to seek

mental health services. Broman focused on a broad range of problems,

discovering that African Americans often seek mental health services for economic

and physical problems. If Broman had included emotional and interpersonal

problems in his study, the results would have been consistent with other research;

that is, African Americans underutilize mental health services. Acosta (1979)

concluded that many cultural barriers prevent Mexican Americans from seeking

mental health services, even though their perception of mental health services is

positive. Like all groups, however, the financial cost of mental health services

may be the greatest barrier to serving Mexican Americans (Woodward, Dwinell, &

Arons, 1992).

The U.S. military has become a model of racial integration (Moskos &

Butler, 1996). Minority groups make up approximately 21% of the USAF, with

African Americans comprising 15% and Hispanic Americans 3%. From the above

analysis, it might be easy to conclude that since minorities have low rates of help

seeking and make up a substantial part of the USAF that low levels of help seeking

among USAF members should be expected. Unfortunately, no analysis of help-

seeking behavior in the military has been broken down by ethnicity or race.

Ethnic and racial considerations may explain some of the help-seeking behavior of

USAF members but has several limitations. For example, the majority of officers

is Anglo American (88%), yet they are notably the least likely to use mental health

services. In addition, Knesper et al. (1985) and Woodward et al. (1992) pointed

out that financial constraints may play an equal or even more significant role in minorities seeking help. Services to USAF members are free; therefore, this factor should be eliminated and help-seeking rates should be higher.

Demographic Conclusions

A comparison between help seekers in the general population and USAF military members reveals stark differences. The typical help seeker in the general population is a highly educated woman, Anglo American, and between the ages of 25 and 45. The typical USAF member, on the other hand, is less likely to be Anglo American or educated, more likely to be male, and less than 25 years old. Therefore, low rates of help seeking in the USAF should not be surprising given the demographic makeup of this military branch. Unfortunately, demographic characteristics show who seeks mental health services, but they do not fully explain the underlying reasons people decide to get help.

Theoretical Perspectives of Help Seeking

Several researchers have proposed a variety of theories to analyze and explain help-seeking behavior (Snowden et al., 1982; Wills, 1987), including instrumental, reciprocity, self-esteem, relational, attitudinal, and coping. Unfortunately, none of these theories adequately explains help-seeking behavior (Wills, 1987). For this analysis, three theories were selected: (a) attitude, (b) common sense, and (c) rational. Like other theories, these do not entirely explain help-seeking behavior but combined may provide a more complete explanation of

help-seeking behavior.

Attitude Theory

Attitude theory posits that attitudes predict behaviors, and it has been used extensively to explain the behavior of groups and individuals (Krosnick & Petty, 1995; Petty & Cacioppo, 1981). The theory is based on the assumption that people have attitudes toward their world and that these attitudes predict actions.

Various researchers have characterized attitude theory slightly differently, with Zimbardo and Leippe's (1991) explanation appearing to be the most complete. They explained that people have attitude systems. These systems consist of behaviors, behavior intents, cognitions, and affective responses, making up a mental representation of which the attitude is the summary evaluation. In other words, people interact with their world, forming opinions and beliefs that predict how they will interact in the future.

The ability of attitudes to predict behavior is questionable. Petty and Cacioppo's (1981) review of attitude studies revealed that many psychologists have found little evidence to support a connection between attitudes and behavior. Petty and Cacioppo argued, however, that most of the attitude research was poorly constructed and conducted. They concluded that more recent studies using carefully constructed instruments showed a clear relationship between attitudes and behavior.

Attitudes and help-seeking behavior. An attitude theory proposed by Fischer and Turner (1970) appears to have a lot of empirical support because a

measure based on their theory has been widely used by help-seeking researchers (Fischer, Winer, & Abramowitz, 1983). Fischer and Turner investigated the relationship between attitudes and help seeking. In a study of three sample groups, they found four factors that represented various aspects of attitudes related to help-seeking behavior. Fischer et al. (1972) added two more factors in another analysis 2 years later. From their study and others (deBarot, 1977), it appears that the theoretical help seeker (a) recognizes a personal need for professional psychological help, (b) tolerates stigma well, (c) is interpersonally open, (d) has confidence in mental health professionals, (e) does not have a high need for rugged independence, and (f) is willing to seek help.

Fischer and colleagues (1983) admitted that a study predicting actual help seeking using an instrument based on these attitudes has not been conducted; however, they did find a significant correlation between demographic characteristics, attitudes, and help-seeking behavior. For example, Fischer and Cohen (1972) found that Jews have more positive attitudes toward help seeking than Protestants or Catholics. Jews also are overrepresented as a help-seeking population (Fischer et al., 1983; Veroff et al., 1981). Johnson (1988) found that women have more positive attitudes toward help seeking than men. Women are also more likely to seek professional mental health services than men (Veroff et al., 1981).

Common-Sense Theory

The common-sense theory was developed from research conducted on chronically ill patients. Leventhal, Nerenz, and Steele (1984) believed that patients form "common-sense" perceptions of their health problems, with these perceptions leading to different representations, coping strategies, and appraisals.

Leventhal et al. (1984) listed four basic assumptions of the common-sense theory. Their first assumption was that an underlying informational processing system controls human behavior and experiences. They believed that human behavior and experiences come from memories and codes that create coping reactions. Their second assumption was that people respond to illness along parallel pathways, developing an objective or concrete view of the problem and formulating a coping plan to deal with it. People also create an emotional response and devise a plan to deal with the emotional aspect of an illness. Parallel processes develop through three stages, which is the third assumption. First, people develop a representation of their illness. They look for the causes of their illness and its consequences. They also try to identify their symptoms and give their illness a label. Finally, they project how long it will take to be cured of their illness and how long their illness will affect them. The emotional and objective pathways are dependent upon each other and are linked by a feedback loop. People may first recognize an emotional abnormality, causing a cognitive evaluation that leads to more emotional representations. On the other hand, they also may recognize their physical symptom first and form an emotional

representation that affects the cognitive evaluation. A good example of this process may be a simple headache. If people represent a simple headache as a brain tumor, their emotional response of panic may exacerbate their symptoms.

The next stage in the process is coping. In this stage, people select a coping mechanism that deals with the concrete and emotional manifestations of their illness. The emotional representation affects and is affected by the concrete coping strategy. For example, seeing a doctor may be the concrete coping plan, but this step may invoke so much anxiety that it is only taken reluctantly. On the other hand, patients may cope with their emotions through appropriate mechanisms such as rational thinking (Ellis & Dryden, 1987) and lessen anxiety that, in turn, leads to taking concrete action.

The third stage involves the appraisal of the coping strategy. Patients evaluate whether or not their coping strategy helped meet their goals. Again, this stage involves a parallel track in which the concrete manifestations of the symptoms, as well as the emotions, are involved. Each individual has different outcomes based upon the representations of the illness. The concrete symptoms of an illness may disappear, but the emotional component may continue. For example, breast cancer survivors continue to have emotional concerns long after their cancer is in remission (Flint, 1995).

The final assumption involves hierarchical processing. Each stage of the common-sense theory involves concrete and abstract features. These features influence the way in which patients understand their illness and treatment.

Concrete and abstract features can be thought of as end-points on a continuum of understanding. Concrete features can be easily recognized by a patient such as pain or visible evidence of illness. Abstract features require judgment and information in order to understand. For example, people understand they have human immunodeficiency virus (HIV) infection in the abstract because they can view test results. Concretely, however, they may feel no symptoms and, thus, have a difficult time convincing themselves they are sick.

Social comparison also plays an important role in this theory, which involves comparing attitudes and performances with others in order to evaluate or enhance oneself (Wills, 1983). In general, social comparison might be thought of as "simply keeping up with the Jones"; that is, people look at how their neighbors are doing to assess themselves. In the common-sense theory, however, social comparison is involved in the representation, coping, and appraisal stages. People compare how members of their social network view illness, select coping strategies, and appraise progress. Social comparison may even be a coping mechanism, which involves people seeking solace by comparing themselves to others (Wills, 1983).

This summary has simplified a complex theory of coping, but the key elements have been delineated in order to apply the theory to mental health problems and help seeking. From this theory's perspective and in order for people to seek help, they must first represent their problems as psychological in cause and then identify them with a psychological label. Veroff et al. (1981) concluded that

labeling a problem as psychological is an essential step in the decision to seek help. People also must recognize the potential consequences of their problem and then access the timeline. From this analysis, they may select help seeking as a coping strategy and, consequently, appraise their progress against their goals. Relief of psychological distress is probably the goal of most people seeking psychological help.

The common-sense theory provides some assistance in explaining help seeking, but it does a better job explaining why people do not seek help. Because most people do not seek help, they apparently do not represent their problems as mental health concerns; instead, they represent them as spiritual or medical problems, accounting for the high rate of help seeking from ministers and physicians (Veroff et al., 1981). The common-sense theory also shows that help seeking is not the coping strategy used by people who represent their problems as psychological in nature; that is, most go to friends and family first when they have problems. Help seeking may be the last resort for most people with psychological problems (Gourash, 1978).

Rational Theory

One problem with attitude and common-sense explanations is that they focus on individuals and neglect the institutional and cultural components of help seeking. The USAF is an institution and a culture; as such, it influences the behavior of its members. Organizations socialize their members with values, norms, and "acceptable behavior" (Denhart, 1981). Therefore, organizational

theories are also helpful in understanding help-seeking behavior. For this dissertation, rational theory of organizations and help seeking in the military were examined.

Rational theory posits that an organization's primary goal is efficiency (Weber, 1964), with the actions of an organization based on rationality, impersonality, and hierarchical authority (Denhart, 1981). The greatest contributor to the modern understanding of organizations is Weber (1964). His influence is clearly seen in the rational theory of organizations (Clegg, 1990).

According to Denhart (1981), rational theory assumes that organizations are social systems in which structure, stable role expectations, and goals are strongly emphasized. Hierarchy is especially important in organizations, with leaders forming the nature of the relationships between workers. Denhart noted, "Through manipulation of power and authority, the leadership exercises dominance over the activities of persons in the organization" (p. 20). This dominance can be directly applied, but the rational theory posits that an organization molds the wills of its employees so that their norms, values, and behaviors conform to those of the organization. The employee is shaped to be an efficient worker who is subordinate to the purposes of the organization (Denhart, 1981).

Few organizations would fit the rational theory's description more than the military. The military literally indoctrinates new recruits through basic training. The transformation process is so complete that many have referred to the military as a culture (Knox & Price, 1995; Kutz, 1996). Military members are focused

toward one goal: combat (Wood, 1982). From a rational theory perspective, military leaders control or influence their subordinates to work efficiently toward this end.

Mental health services in the military serve a similar end. From the rational theory perspective, mental health services in the military contribute to the goal of the military by insuring that each member works efficiently towards being "combat ready." This theory might also presume that help-seeking behavior must fit the organization's goals.

Theoretical Conclusions

Each of these theories offers possible explanations of help-seeking behavior in the military. From an attitude-theory perspective, the military is comprised of people whose attitudes may be inconsistent with help seeking. The typical help seeker is the antithesis of the typical military member and the combat masculine warrior paradigm. Fischer and Turner (1970) concluded, "To some degree the help seeker must be open to others, to his [sic] personal 'weaknesses,' and must be unswayed by what others may think of psychiatric patients" (p. 85). Many military members may not be open to others; some may despise weakness and stigmatize help seeking. These attitudes may be the most important reasons military members avoid seeking help. Still, the lack of empirical support for the attitudes theory's ability to predict help seeking is a shortcoming. The common-sense theory may provide a better explanation of military help-seeking behavior.

From a common-sense theory perspective, military members are part of a community that may offer some support for problems. More likely, however, when people view their problems through social comparison, they may decide to avoid help seeking because it is inconsistent with the "normal behavior" of military people. Their "common-sense" representations tell them that their problems are not psychological and would not benefit from mental health services. In addition, many military people are unaware of the availability of mental health services; therefore, they do not use these services as a coping mechanism.

The organizational perspective of the rational theory highlights different explanations of help seeking and, more importantly, of the barriers to obtaining help. USAF members may fear that seeking help will negatively impact their careers; that is, if their problems interfere with the goal of the USAF, they may be asked to leave the organization. In addition, rational theory posits that the goal of the organization is paramount and that organizational leaders try to control employees. In the case of the USAF, the goal is to prepare for combat, with USAF leaders appearing to have a high need to control their subordinates. Providing absolute confidentiality interferes with the goals of the USAF and the ability of USAF leaders to control. The USAF is an organization that appears to have a low threshold for internal secrecy. From the rational theory perspective, the organization influences members to conform to a worker ideal. USAF members who need help for problems or who are mentally ill may not conform to the model of the ideal: efficient worker. Therefore, USAF leaders may state that

help seeking is acceptable behavior and will not result in negative consequences, but the USAF has already trained USAF members with norms, values, and acceptable behaviors inconsistent with seeking professional mental health services. Finally, USAF members may also recognize that their behavior must conform to the "combat-ready" goal if they are to remain in the organization. Consequently, if members do not view help-seeking behavior to be consistent with the goals of the military, they may avoid using these services regardless of the problem.

Overall, attitude, common-sense, and rational theories offer some explanations for help-seeking behavior in the military. From the attitude theory perspective, USAF members may have attitudes inconsistent with those of help seekers. From the common-sense theoretical perspective, members of the USAF may not represent their problems in mental health terms and, thus, not consider mental health services as an option. The rational theory perspective shows that help seeking may be inconsistent with the goals of the USAF and the norms, values, and acceptable behaviors each USAF member is influenced to accept.

CHAPTER IV

METHODOLOGY

In this chapter, the methodology is explained. This methodology includes research design, sampling procedures, instrument, data collection procedures, and data analysis.

Research Design

Descriptive studies are designed to describe events and situations and, in fact, are the most common form of research (Rubin & Babie, 1997). Descriptive studies usually rely upon descriptive statistics such as measures of central tendencies, dispersions, and distributions. Two advantages of descriptive studies are (a) the ease of statistical analysis and (b) the limitation of intervening variables (Rubin & Babie, 1997).

Studies of help-seeking behavior have been primarily descriptive (Fischer & Farina, 1995; Horwitz, 1977; Johnson, 1988; Veroff et al., 1981). Researchers (Harlow & Cantor, 1995) have examined the relationship between problems and help seeking, whereas others (Kelly & Achter, 1995) have examined attitudes toward help seeking and actual help-seeking behavior; however, even these studies were descriptive.

Consistent with previous research, this study was primarily descriptive. Predictive methods, however, were used in forecasting the most likely USAF members to seek mental health services.

Sampling Procedures

A random sample of 1,000 USAF members was solicited to participate in this study. The Air Force Institute of Technology (AFIT) provided the names and addresses for this randomly selected sample.

Each potential respondent received a letter explaining the study (Appendix A), a survey (Appendix B), and a stamped/self-addressed return envelope. Based upon previous research (Albano, 1991; Bray et al., 1992; Crosby & Hall, 1992), a return rate between 10% and 50% was expected. After reviewing the proposal, C. Hamilton, chief, USAF survey branch (personal communication, June 4, 1997) stated that he would expect a 50% return rate and that the survey branch considered a sample size of 380 to be representative of all USAF personnel. Narins (1994) found that a sample of 384 was necessary in order to represent an infinite population at the 95% confidence level. The response rate for the present study was only 40%, with the number of respondents exceeding the 384 needed.

Of the 1,000 surveys mailed, 391 usable surveys were returned. During the first few weeks, 65 of the mailers were returned as "undeliverable." Most of the addressees were no longer stationed at the addresses and some had separated from the USAF. Sixty-five additional surveys were mailed to make up for the shortfall. At the end of the research, only 15 mailers had been undeliverable, making the

potential sample size 985.

Sample Demographics

Comparing the sample with the most recent USAF demographics (Air Force

Personnel Center, 1997) shows that the sample for this study was representative of

the USAF at large; however, some differences were noted. Officers were

overrepresented, but this difference was a result of the initial sample purposively

being evenly divided between officers and enlisted members (Table 1).

Table 2 shows significant differences between the proportion of various

enlisted members in the USAF and those found in this sample (p = .009). Middle

grade (E5-E6) and senior enlisted members (E7-E9) were overrepresented, whereas

junior enlisted members were underrepresented (E1-E4). The trend of higher

ranking members responding continued in the officer ranks, but the difference was

not significant (p = .345).

Table 1

Percentage of Officer and Enlisted in Sample and the U.S. Air Force At Large

Variable	N	%	USAF %
Officer	212	54.5	19.7
Enlisted	177	45.5	80.3
Total	389[a]	100.0	

[a]Two respondents did not list their rank.

Table 2

Officer and Enlisted Composition of Survey Respondents and the U.S. Air Force

Rank	$\underline{N}$	%	USAF %	χ^2	$\underline{p}$
		Enlisted			
E1-E4	67	37.8	49.6	9.3626	.009
E5-E6	80	45.2	37.0		
E7-E9	30	17.0	13.4		
Total	177	100.0	100.0		
		Officer			
01-03	130	61.3	64.6	.8936	.345
04-05	82	38.7	35.4		
Total	212	100.0	100.0		

Despite differences in the number of officers and enlisted members in the sample, in general, it appeared to be representative of the USAF population for the remaining variables. The average age of officers and enlisted members was 1 year lower than the USAF averages, with sample ages at 34 and 29, respectively. As shown in Table 3, this sample had significantly ($\underline{p}$ = .017) more women than are represented in the USAF at large, but this disproportionality helped in making more valid comparisons between men and women. In terms of race, this sample was not statistically different than the USAF (Table 4). Unfortunately, the low number of minority respondents made comparisons between races unreliable.

Table 3

Gender Breakdown of Survey Respondents and the U.S. Air Force

Variable	$\underline{N}$	%	USAF %	χ^2	$\underline{p}$
Males	269	79.4	84.1	5.7175	.017
Females	70	20.6	15.9		
Total	339	100.0	100.0		

Table 4

Officer and Enlisted Composition of Survey Respondents and the U.S. Air Force

Rank/race	$\underline{N}$	%	USAF %	χ^2	$\underline{p}$
		Enlisted			
Anglo American	121	79.6	77.9	.3512	.950
African American	20	13.2	14.6		
Hispanic American	5	3.3	3.7		
Other[a]	6	3.9	3.8		
Total	152	100.0	100.0		
		Officer			
Anglo American	179	92.3	88.5	4.7294	.193
African American	9	4.6	5.6		
Hispanic American	4	2.1	2.0		
Other[a]	2	1.0	3.9		
Total	194	100.0	100.0		

[a]The available demographic data on USAF members list only three categories of race and place the remaining races in the "other" category. Among survey respondents, 4 listed themselves as Asian American, 2 as Native American, and 2 as "mixed race."

Exact comparisons of the variables of education, current marital status, and years in service were difficult because the USAF categorizes these data differently. In terms of education, almost 100% of the USAF members have high school degrees. Table 5 indicates that among enlisted respondents 18.3 have college degrees and 63.5 have some credit towards a degree. These rates were identical to the rates in the USAF. Among officers, however, the number of respondents with graduate degrees was slightly more than 10% higher than the rate in the USAF.

The number of married survey respondents was 70%, which is very close to the USAF married rate of 68% (Table 6). Comparison to the other categories was not available. In terms of years of services, the sample was fairly well-distributed across the first four categories. Since USAF members may retire after 20 years of service, it was not surprising that less than 6% had 21 years or more of service. On average, among all USAF members, officers average 10.9 years of service and enlisted 9.0 years. Overall, this sample was slightly skewed to higher ranking and contained more educated members of the USAF but still appeared to be representative of the USAF at large.

Instrument

The Military Survey of Attitudes Towards Services (MATS) (Appendix C) was used for this study. This instrument was constructed by this researcher. After an extensive review of the literature, a survey was developed and given to 18 active duty USAF members to solicit input. This sample represented a broad range of different USAF specialties, including military mental health professionals.

Table 5

Education Level of Officer and Enlisted Survey Respondents

Education level[a]	N	%
Enlisted		
High school	30	17.1
Some college	111	63.5
College degree	32	18.3
Graduate degree	2	1.1
Total	175	100.0
Officer		
College degree	75	35.2
Graduate degree	138	64.8
Total	213	100.0

[a]Education displayed is the highest education level obtained.

Table 6

Marital Status and Years of Service of Survey Respondents

Variable	N	%
Current marital status		
Married	271	69.5
Divorced	30	7.7
Never married	86	22.1
Other	3	.9
Total	390	100.0
Years in USAF		
1-5 years	100	27.2
6-10 years	92	25.0
11-15 years	86	23.4
16-20 years	69	18.8
21+ years	21	5.7
Total	368	100.0

Their feedback resulted in some questions being discarded and others being rephrased. The sample, however, supported the content validity of the survey. They agreed that barriers contained in the MATS were consistent in their observations concerning barriers to accessing mental health services in the USAF. Once a final version was constructed, 38 USAF cadets were sampled. Their responses indicated an internal consistency or a Cronbach's alpha of .77 across the different barriers, indicating some differences between the barriers and at the same time enough agreement to account for 77% of the variance in the true score. Overall, these pilot studies showed that the MATS had adequate validity and reliability. The final instrument combines a published survey and several questions constructed from the literature. The MATS contains 21 items related to barriers of accessing mental health services and attitudes toward help seeking. The first section contains questions related to demographic characteristics, including age, gender, rank, marital status, education level, race, and job classification. The next section examines perceptions concerning help seeking in the military. These questions ask respondents to rate different barriers with different helping sources. Question 1 evaluates fear of negative career impact; Question 2 examines the perception of confidentiality; Question 3 looks at the perceived abilities of different helpers; Question 4 explores the stigma or embarrassment associated with help seeking; and Question 5 looks at the cultural view of USAF members who seek help and who are considered "weak."

The different helping sources were chaplains, commanders, mental health professionals, physicians, and friends—all associated with the military. Veroff et al. (1981) found that ministers, physicians, and friends were the most prominent sources of help. Commanders are an advertised helping source in the USAF. In a survey of more than 30,000 USAF members, more than half reported friends as a source of support, whereas less than 10% reported using military facilities or the help of commanders or first sergeants (D. Wolpert, chief, USAF family research, personal communication, September 16, 1997). Unfortunately, this research did not specify mental health problems or services, whereas the present study examined these areas.

Participants evaluated the extent that each barrier influenced USAF members from seeking help. With the exception of Question 3, all of the questions were phrased so that participants evaluated a USAF norm or value. This phrasing may have decreased socially desirable answers and yielded more accurate information on USAF organizational norms. The focus on norms was consistent with rational theory, which informed this study.

The third section examines attitudes toward help seeking. Questions 6 through 15 were modified items from the Attitudes Toward Seeking Professional Psychological Help (ATSPPH) scale developed by Fischer and Farina (1995). In their article, Fischer and Farina gave permission for this instrument to be used without their consent. Fischer (personal communication, March 26, 1997) also stated that the instrument may be modified to suit each researcher's needs but

should be noted as modified. For this study, the instrument was modified to simplify the language and to eliminate jargon.

The ATSPPH has been used extensively to examine attitudes toward help seeking. The original version of the ATSPPH was a 29-item instrument constructed by Fischer and Turner (1970). During the last 25 years, researchers have used the ATSPPH to examine the relationship between attitudes and demographic factors related to help seeking (Fischer et al., 1983; Surgenor, 1985). Some of these studies include examining attitudes toward seeking mental health services of adults and adolescents from a variety of cultures (Cash, Kehr, & Salzbach, 1978; Dadfar & Friedlander, 1982; Furnham & Andrew, 1996; Johnson, 1988; Tata & Leong, 1994; Tedeschi & Willis, 1993); men and women (Johnson, 1988); lesbians (Morgan, 1992); suicide attempters (Turner & Morgan, 1979); and people suffering from depression (Strohmer, Biggs, & McIntyre, 1984).

The 1995 version of the ATSPPH is a shortened form of the original. The 1970 version contained four factors related to help seeking, but these factors lacked internal consistency (Fischer & Farina, 1995). The modified version is unidimensional and contains only 10 questions. The correlation between the old and new versions is .87. The internal consistency of the modified ATSPPH is high (Cronbach's alpha = .84), and the test-retest correlation is good (.80 between two test periods 1 month apart). Since this instrument stands alone, its ability to examine help-seeking attitudes (comprehensive criterion-related validity) is questionable.

An advantage to using the ATSPPH in the present study was based upon the theory constructed by Fischer and Turner (1970). The instrument also directly examines factors found in the literature review of barriers to accessing mental health services in the USAF.

Questions 16 and 17 return to examining perceptions of help seeking in the USAF. Question 16 evaluates the amount of help USAF members perceive as being available to them, and Question 17 looks at the confidence of mental health professionals (similar to Question 3).

The last section provides demographic data concerning help-seeking behavior. Questions 18 and 19 inquire whether or not the respondent has ever voluntarily sought mental health counseling or been forced to seek help. Question 20 asks whether or not respondents have considered seeking help, and Question 21 asks whether or not they have sought help from a civilian mental health professional because they did not want to go to their base mental health facility. The last section also offers participants the opportunity to comment further on their attitudes toward help seeking in the USAF.

Data Collection Procedures

Potential participants were sent a cover letter, survey, and stamped/self-addressed return envelope. The cover letter explained the reasons for this study, emphasizing the confidentiality of responses and the voluntary nature of the survey. This letter also stressed to participants that it would be impossible for anyone to identify them from their surveys. No follow-up letter was sent. Since the identity

of participants was unknown, an exemption from the University of Utah

Institutional Review Board was requested and approved. The USAF Survey

Branch also approved the request to survey USAF members.

Data Analysis

The data were collected and entered into SPSS for Windows (a

comprehensive statistical computer program). The initial analysis examined

demographic characteristics of the sample and compared them to the USAF

population. The results of this analysis were contained in Tables 1 through 6.

Data from the MATS were analyzed. This step involved tabulating ATSPPH,

barrier, and helping-source scores. An explanation of these procedures follows.

Attitude Towards Seeking Professional
Psychological Help Inventory

The ATSPPH was constructed by Fischer and Farina (1995). The sum of

the responses indicates the attitudes toward seeking mental health services. The

higher the score, the more favorable the attitude.

An ATSPPH score was computed for each respondent. After reverse

scoring Questions 7, 9, 13, 14, and 15, a score of Questions 6 through 15 was

summed. Because several respondents left some questions unanswered, these

blanks were filled with a score of 2.5, which represented a neutral response.

Many of the respondents who failed to answer these questions indicated a desire to

respond in a neutral fashion. This adjustment allowed another 22 scores to be

counted, which ordinarily would have been dropped. In order to compare these

results with those obtained by Fischer and Farina (1995), 10 points were added to their results. Fischer and Farina used a zero to three 4-point scale; this scale was replaced with a one to four 4-point scale.

The resulting collection of ATSPPH scores indicated a wide variation in responses. Table 7 shows that the average score was 25.1, which represents a neutral score between a potential range of scores (10 to 40). The distribution was neither significantly skewed nor kurtosed, and the mean appeared to be representative of the data. A visual inspection of the data also supported a conclusion that this variable was normally distributed. Therefore, the assumption concerning normalcy for parametric tests was met.

Barriers and Helping Sources

The term "barriers" was synonymous with factors identified in the literature as possible impediments to accessing mental health services. For this analysis, however, two barrier computations were made. The first barrier summed the responses for all helping sources into a single barrier score. For example,

Table 7

Distribution of Attitudes Towards Seeking Professional Psychological Help Scores

	N	X̄	SD	Range	p skewness[a]	p kurtosis[b]
ATSPPH	391	25.1	5.7	29	.63	-1.24

[a]Pearson skewness coefficient.

[b]Pearson kurtosis coefficient.

Question 1 on the MATS asked respondents to rate the negative career impact of seeking help from five helping sources. By summing these responses, a single barrier entitled "fear of negative career impact" was computed.

The second barrier computation involved summing across the first five questions of the MATS in order to compute a total barrier score for each helping source. For example, a total score for barriers to accessing chaplains for help was computed by adding the responses to Questions 1 through 5. Throughout this analysis barriers for each helping source are examined and compared.

These scores were ordinal-level data; therefore, questions of normalcy are unimportant because nonparametric tests were used with these data. Similar to ATSPPH scores, empty cells were filled with 2.5 (representing a neutral response), adding 4 cases to the study. Questions 2 and 3 were reversed scored. For all of these questions, higher scores indicated that respondents agreed that these factors were barriers to accessing help. The possible range of scores was 5 to 20. In the case of barriers, a mean score higher than 12.5 indicated that respondents believed it was a factor. For helping sources, this score showed whether or not the barriers were factors with each helping source.

Statistical Analysis

A variety of parametric and nonparametric statistical tests was used in this dissertation. This section discusses the use of these tests and their underlying assumptions. Many of the parametric assumptions were taken from Hinkle, Wiersma, and Jurs (1994), with the nonparametric assumptions taken from Pett

(1997). An assumption underlying all of the tests in this study was that the sample be randomly selected. This sample was not randomly selected but self-selected.

The parametric tests included analysis of variance (ANOVA), independent t tests, and multiple linear regression. The tests were used with ATSPPH scores because this variable was interval-level data (an assumption of all parametric tests in this study). Another assumption of these tests, which was met, is that the dependent variable (ATSPPH scores) be normally distributed (Table 7). The assumption of homogeneity of variance required for an ANOVA and independent t tests was also met. The linear regression model has several other assumptions, including that the independent variables should be continuous or dichotomous. This assumption was met. This test met the requirement for homoscedacity and errors being normally distributed. None of the variables was correlated at more than .80, which is the final assumption of linear regression.

The nonparametric tests included chi-square, Friedman Test, Wilcoxon Signed Ranks Test, Mann-Whitney U test, Kruskal-Wallis One-Way ANOVA, and Spearman rho correlations. These tests were appropriate because the statistics concerning barriers and helping sources were ordinal-level data. The assumptions for all tests were met.

Survey Responses

One hundred twenty-one respondents wrote comments on the bottom of their surveys. These comments were analyzed and are reported in Chapter V. The comments were read and reread until themes, patterns, and clusters emerged,

which is consistent with the recommendations of Huberman and Miles (1994).

This analysis also discovered relationships and developed explanations. Finally,

the comments were presented in various categories.

CHAPTER V

RESULTS

In this section, the results of the present study are given, and each research question is addressed. First, attitudes toward help seeking of USAF members are compared with the attitudes of civilians. Next, responses to questions concerning barriers to help seeking and help sources are examined. After this analysis, characteristics of different subgroups within the sample are examined in regard to barrier ratings and attitudes toward help seeking, including an analysis of help seeking with regard to rank, gender, marital status, years of service, and job category. The characteristics of voluntary, forced, and civilian help seekers are also examined. Finally, a linear regression model is proposed that predicts ATSPPH scores and identifies the key variables related to attitudes toward help seeking.

Research Question 1

Are there substantial differences between the general attitudes toward seeking mental health services among USAF members and those among civilians?

A comparison between the ATSPPH scores of USAF members in this sample and civilians in the Fischer and Farina (1995) study revealed that USAF

members have significantly less positive attitudes toward seeking mental health services than their civilian counterparts (p = .001). In the Fischer and Farina study, the adjusted mean score was 27.5 compared to 25.1, as recorded by USAF members in this sample. When separated by gender, however, only men in this study had significantly lower scores than those in the Fisher and Farina study (Table 8). Women in this study had lower scores as well, but the difference was not significant probably because of the relatively few women in this study (Table 8).

Conclusions from direct comparisons may be problematic. Fischer and Farina (1995) sampled 389 students enrolled in an introductory psychology course. The modal age of their sample was 18 years. In order to examine similar age

Table 8

One-Sample T Test Comparing Attitude Towards Seeking Professional Psychological Help Scores From Different Samples

Category	$\underline{N}$	$\overline{X}$	$\underline{SD}$	μ^a	$\underline{t}$ value	$\underline{p}$
Males	269	24.2	5.7	25.5	-3.52	.001
Females	70	28.0	5.8	29.1	-1.42	.160
Young males	29	22.1	5.2	25.5	-3.40	.002
Young females	14	27.5	5.0	29.1	-1.19	.257
Overall	391	25.1	5.7	27.5	-7.96	.001

[a]Fischer and Farina (1995) used a 30-point scale starting at 0. For the present study, a 10- to 40-point scale was used. Therefore, 10 points were added to the means obtained in the Fischer and Farina study to make a comparison of the present study. This action resulted in no differences.

groups, the sample was recategorized into two groups: (a) 23 years old and younger and (b) 24 years old and older. A comparison between younger and older men and women in this sample revealed that younger men were significantly more negative in their views of seeking psychological help than older men (p = .027), but there was no significant difference between age groups of women (p = .674). Comparing the younger groups to the results from Fischer and Farina's study showed, again, that younger USAF men were significantly less inclined toward seeking help than their civilian counterparts (p = .002), but USAF women were not as inclined (p = .257) (Table 8). Unfortunately, the size of these subsets was very small; therefore, conclusions must be used with caution.

Research Question 2

Are there significantly more barriers to seeking help from military mental health professionals than from chaplains, commanders, physicians, or friends?

The answer to this question is a resounding yes. USAF members in this study perceived significantly more barriers in seeking help from military mental health professionals than from any other helping source examined. The highest barrier score belonged to mental health professionals ($\overline{X}$ = 14.23), whereas respondents perceived the fewest barriers when seeking help from chaplains ($\overline{X}$ = 8.80) (Table 9). Only commanders and mental health professionals were higher than the neutral 12.5.

Table 9

Friedman Test Evaluating Overall Perception of Helping Sources Across Barriers and Post Hoc Wilcoxon Signed Ranks Tests
Comparing Mental Health Professionals to Other Helping Sources

| Helping source | N | $\overline{X}$ | SD | Rank | Wilcoxon | | Friedman | | |
					z	p	χ^2	df	p
Chaplains	391	8.80	2.88	1.75	-16.52	.001	759.37	4	.001
Commanders	391	12.78	3.11	3.69	- 8.90	.001			
Physicians	391	11.50	3.13	2.99	-14.33	.001			
Friends	391	9.67	2.63	2.21	-15.03	.001			
Mental health professionals	391	14.23	3.26	4.37					

The Friedman Test indicated that these differences were significant

(p = .001). This test, however, does not indicate the location of these differences.

Therefore, a Wilcoxon Signed Ranks Test compared barriers to accessing mental

health professionals with other helping sources as a post hoc measure (Pett, 1997).

Repeat post hoc multiple comparison tests increase the probability of making a

Type 1 error; therefore, subsequent adjustment of significance levels is

recommended (Hinkle et al., 1994). The results of this test, however, indicated

that this adjustment was irrelevant; that is, all of the resulting probabilities were

.0001, indicating significantly more barriers to accessing services from military

mental health professionals.

The combination of barriers clearly hindered help seeking from mental

health professionals, with the analysis of each barrier sometimes yielding different

results. Research Question 2 contained five subquestions. These questions are

addressed, and each barrier is individually examined.

Fear of Negative Career Impact

USAF members appear to fear more negative career repercussions from

seeking help from military mental health professionals than from chaplains,

physicians, and friends. They saw no difference in this variable between mental

health professionals and commanders. The Friedman Test found a significant

difference among the groups (p = .001) (Table 10). The Wilcoxon Signed Ranks

Test indicated that there were significantly more career concerns with seeking help

from mental health professionals than from chaplains, physicians, or friends

Table 10

Friedman Test Evaluating Fear of Negative Career Impact for Help Seeking and Post Hoc Wilcoxon Signed Ranks Tests Comparing Mental Health Professionals to Other Helping Sources

Helping source	N	$\overline{X}$	SD	Rank	Wilcoxon		Friedman		
					z	p	χ^2	df	p
Chaplains	391	1.40	.73	1.85	-15.20	.001	690.94	4	.001
Commanders	391	2.80	1.05	3.80	-1.16	.247			
Physicians	391	2.40	1.00	3.20	-8.69	.001			
Friends	391	1.73	.86	2.28	-13.00	.001			
Mental health professionals	391	2.86	1.01	3.87					

($\underline{p}$ = .001), but no significant difference was found on this variable between seeking help from commanders and first sergeants and seeking help from a mental health professional. In fact, an examination of the means for this barrier shows that only mental health professionals and commanders/first sergeants were higher than the 2.5 mean.

This result may be surprising given the actual power difference between these sources. Commanders and first sergeants can take direct disciplinary action against their subordinates, whereas mental health professionals have no direct power over their clients. In fact, their influence is virtually identical to military physicians.

Confidentiality

This sample indicated that military mental health professionals offer more confidentiality than commanders and first sergeants but no more than friends and physicians and significantly less than chaplains. The Friedman Test showed significant differences between the groups, with the post hoc test indicating that these differences were significant for commanders and first sergeants (Table 11).

Except for chaplains who respondents believed granted the most confidentiality ($\overline{X}$ = 1.64), none of the helping sources scored below the 2.5 neutral response. In other words, this sample perceived a general lack of confidentiality when talking about personal problems with almost all helping sources. Of further concern was the fact that the sample saw no significant difference between talking about personal problems with mental health

Table 11

Friedman Test Evaluating the Perceived Lack of Confidentiality Among Helping Sources and Post Hoc and Wilcoxon Signed Ranks Tests Comparing Mental Health Professionals With Other Helping Sources

Helping source	N	$\overline{X}$	SD	Rank	Wilcoxon		Friedman		
					z	p	χ^2	df	p
Chaplains	391	1.64	1.03	1.86	-11.96	.001	410.64	4	.001
Commanders	391	3.01	.93	3.76	- 6.56	.001			
Physicians	391	2.56	1.00	3.09	- 2.05	.041			
Friends	391	2.57	1.03	3.05	- 1.00	.316			
Mental health professionals	391	2.65	1.04	3.23					

professionals and friends in terms of confidentiality, despite regulations protecting communication between mental health professionals and clients.

Skills of Mental Health Professionals

The sample perceived no differences between the skills of mental health providers to help with personal problems than other helping sources, except chaplains (Table 12). Chaplains were rated as having significantly more skills.

Overall, however, this factor may not have been considered a barrier. None of the means was above the 2.5 neutral response. Somewhat surprising is the fact that there were no significant differences between the skills of commanders, friends, and physicians to help with personal problems and those of trained mental health professionals. One reason may be that USAF members believe that USAF mental health professionals overdiagnose problems. The majority of this sample (59%) agreed or partly agreed that USAF mental health professionals make a "bid deal" out of small problems.

Stigma/Embarrassment and "Weakness" Associated With Help Seeking

Because these questions are related, the respondents' answers are combined in this section. The results indicate that USAF members perceived more embarrassment or stigma and greater feelings of weakness when seeking help from military mental health professionals than from any other helping source in this study.

Table 12

Friedman Test Evaluating Differences in Appraised Skill Level of Helping Sources and Post Hoc Wilcoxon Signed Ranks Tests
Comparing Mental Health Professionals With Other Helping Sources

| Helping source | N | $\overline{X}$ | SD | Rank | Wilcoxon | | Friedman | | |
					z	p	χ^2	df	p
Chaplains	391	1.76	.88	2.27	-9.45	.001	158.72	4	.001
Commanders	391	2.31	.91	3.18	-.66	.505			
Physicians	391	2.27	.87	3.15	-1.48	.140			
Friends	391	2.26	.87	3.15	-1.39	.164			
Mental health professionals	391	2.34	.93	3.25					

87

Table 13 indicates that this sample did not associate embarrassment or stigma with seeking help from chaplains, commanders, physicians, and friends; in fact, none of their barrier scores was above 2.5. Seeking help from mental health providers, however, was significantly stigmatizing ($\underline{p}$ = .001) compared to all helping sources.

Table 14 shows that this sample believed that USAF members would feel weak if they sought help from mental health providers ($\overline{X}$ = 3.02) but not from any other helping source. A comparison of mental health professionals and helping sources revealed that these differences were significant ($\underline{p}$ = .001) for all helping sources.

Differences Among Barriers to Accessing Mental Health Professionals

A comparison between the barriers to accessing mental health providers reveals that the stigma associated with seeking their help is the most significant (Table 15). Post hoc tests showed that the embarrassment associated with seeking mental health services was more significant than any other factor ($\underline{p}$ = .001). The next most significant factor was "feeling weak" for seeking help.

This result was somewhat surprising when compared to the literature. Few articles have discussed barriers to help seeking, with the review indicating that USAF members' greatest concerns are associated with negative repercussions of seeking help (Bray et al., 1992; Coolbaugh, 1994a) and lack of confidentiality (Coolbaugh, 1994a). The finding that embarrassment and "feeling weak" were the

Table 13

Friedman and Wilcoxon Signed Ranks Tests Evaluating the Embarrassment USAF Members May Experience in Seeking Help

Helping source	N	$\overline{X}$	SD	Rank	Wilcoxon		Friedman		
					z	p	χ^2	df	p
Chaplains	391	1.97	.99	2.59	-14.76	.001	745.11	4	.001
Commanders	391	2.33	.95	3.15	-14.00	.001			
Physicians	391	2.10	.94	2.79	-14.62	.001			
Friends	391	1.54	.78	1.98	-15.56	.001			
Mental health professionals	391	3.35	.88	4.48					

Table 14

Friedman Test Evaluating Whether or Not USAF Members Feel "Weak" for Seeking Help From Different Sources and Post Hoc Wilcoxon Signed Ranks Tests Comparing Mental Health Professionals With Other Helping Sources

| Helping source | N | $\overline{X}$ | SD | Rank | Wilcoxon | | Friedman | | |
					z	p	χ^2	df	p
Chaplains	391	2.02	.95	2.70	-13.65	.001	630.72	4	.001
Commanders	391	2.33	.95	3.18	-11.32	.001			
Physicians	391	2.16	.92	2.92	-13.10	.001			
Friends	391	1.57	.74	2.00	-15.03	.001			
Mental health professionals	391	3.02	1.00	4.20					

Table 15

Friedman Two-Way Analysis of Variance Test of Different Barriers to Accessing Mental Health Services

Barrier	N	$\overline{X}$	SD	Rank	χ^2	df	p
Question 1 (negative impact on career)	391	2.86	1.01	3.01	308.92	4	.001
Question 2 (lack of confidentiality)	391	2.65	1.04	2.67			
Question 3 (skill level of helpers)	391	2.34	.93	2.23			
Question 4 (embarrassed to seek help)	391	3.35	.88	3.80			
Question 5 (feel "weak" seeking help)	391	3.02	1.00	3.28			

most significant barriers may indicate that career and confidentiality concerns are excuses to avoid help seeking. Lazarus (1978) speculated that potential clients use confidentiality concerns as an excuse to avoid treatment.

Availability of Help

The MATS also asked potential respondents whether or not they believed "plenty of help" for personal problems was available. More than 65% of the sample agreed or partly agreed with this statement. Most believed help was available, with these responses indicating that many (35%) did not. In the section "Civilian Help Seekers," this result is examined more closely.

Conclusion

The results of this study give strong support that these barriers, in fact, hinder USAF members from seeking the services of military mental health professionals. In the next section, these barriers are explored further with different subgroups within the sample.

Research Question 3

Are there substantial differences in the attitudes toward seeking mental health services among USAF members with regard to rank, gender, marital status, years of service, and Air Force Service Code (AFSC)?

The attitudes and perceived barriers toward seeking help vary among different groups in the USAF. In this section, each of the groups identified in

Research Question 3 is examined. These groups were selected because they represented a notable classification in the USAF population such as officer and enlisted member or had characteristics identified as impacting help seeking such as marital status. In general, the analysis examined four areas for each group: (a) differences between overall attitudes toward help seeking, (b) barriers with each helping source, (c) each barrier for all helping sources, and (d) barriers and mental health professionals. This analysis also focused on explaining the help-seeking behavior of different groups.

Officers and Enlisted Members

The most distinct grouping in the USAF is based upon rank. Traditionally, officers have been considered the top managers in the USAF, generally having more education than enlisted members. Officers also have been considered to be the least likely to seek mental health treatment. This trend was confirmed in the present study. Officers were much less likely to have sought mental health treatment voluntarily on base and were also less likely to have been forced into treatment (see Research Question 4).

An examination comparing attitudes toward seeking mental health services failed to explain this phenomenon. No significant differences were found between the attitudes of officers and enlisted members, as indicated by the ATSPPH (p = .208). When examined across the five rank categories, an ANOVA failed to identify significant differences among these groups (p = .571). Therefore, attitudes toward help seeking apparently do not explain the officers' low rate of

using mental health services.

Examining attitudes toward helping sources yielded different results. A Kruskal-Wallis One-Way ANOVA comparing the five ranks and helping sources yielded significant findings (Table 16). These differences, however, appeared to be within the enlisted and officer categories but not between officer and enlisted members. For example, lower-ranking enlisted members and officers held more favorable views of chaplains than higher ranking members. They also were more likely to view help from friends more positively. When asked to evaluate commanders and mental health professionals, however, no significant differences were found between any of the ranks (p = .821). Subsequent Mann-Whitney U test analysis using officer and enlisted categories found that the only significant difference was in the appraisal of physicians as a helping source for "personal problems," with officers having significantly more positive views than enlisted members (p = .001). No significant differences were found between these categories regarding mental health professionals.

A series of Mann-Whitney U tests (looking at the five barriers and mental health providers) failed to show any significant difference between officers and enlisted members. The only question that discriminated these categories was Question 17, which asked whether or not they believed that mental health professionals make a "big deal" about small matters. For this question, officers were more likely to agree than enlisted members (p = .023). This finding suggested that officers may distrust mental health professionals more than enlisted

Table 16

Kruskal-Wallis One-Way Analysis of Variance of Rank and Helping Sources

Helping source	N	χ^2	df	p
Chaplains	389	19.05	4	.008
Commanders	389	3.51	4	.471
Friends	389	26.03	4	.001
Physicians	389	16.52	4	.002
Mental health professionals	389	1.51	4	.821

Note. This table presents the results of five tests. In each test, the independent variable was rank, and the dependent variable was the help source score.

members but the repeated nature of this test may make this result invalid.

Overall, this study failed to explain differences in help seeking between officers and enlisted members. Some evidence supports that officers are more likely to believe that mental health professionals "overdiagnose" or exaggerate problems, but the extent that this finding affects the help-seeking decision is still unknown. Another explanation is that the norms prohibiting officers from seeking help are unconscious and not captured by the MATS. Future research concerning rank differences should address this problem more directly.

Gender Differences

One consistent finding in the help-seeking literature shows that women are more likely than men to have favorable attitudes toward help seeking (Fischer & Farina, 1995) and are also more likely to seek help (Olfson & Pincus, 1994a;

Veroff et al., 1981). Both of these trends held true for this sample.

An independent t test showed than USAF women held significantly more positive views of help seeking than their male counterparts (p = .001). The mean score for women in this sample on the ATSPPH was 28.09 compared to men who averaged 24.24 (Table 17).

Women were also more likely to view chaplains (p = .005) and physicians (p = .005) as significantly more accessible helping sources than men. They also viewed mental health professionals more positively, but this result was not significant (p = .054).

Examining different barriers with gender showed two significant results. USAF women had more faith in the abilities of mental health providers to help with personal problems than men (p = .001), and they were less likely to believe that military mental health professionals overdiagnose or exaggerate the importance of mental health concerns (p = .001).

Overall, USAF women displayed positive attitudes toward seeking help and downplayed the importance of the barriers to help seeking. These factors may explain why women were more likely to have sought mental health services voluntarily than men (p = .023). More than 27% of the women had voluntarily sought help compared to 16% of the men. These findings appear to be consistent with data collected from civilian populations. Women, however, were no more likely to have been forced to seek help (p = .739) or to have sought civilian help (p = .971). USAF men, however, displayed marked negative attitudes toward

Table 17

Independent T Test of Gender and Attitude Towards Seeking Professional
Psychological Help Score

Variable	N	X̄	SD	t value	p
Males	269	24.24	5.70	-5.02	.001
Females	70	28.09	5.82		

help seeking and a general distrust of the capabilities of mental health providers.

Marital Status

Divorced respondents were likely help seekers, which is similar to the

findings in a study of civilians (Veroff et al., 1981). The results of a chi-square

test also indicated that divorced respondents were more likely to have voluntarily

sought help than married, never married, or widowed respondents (p = .009).

They were significantly more likely to have sought help from a civilian mental

health professional than those in other categories (p = .001). Because this study

asked for current marital status only, the accuracy of some of these conclusions

may be somewhat suspect because a respondent could be married but have been

divorced.

Attitudes toward help seeking failed to explain the differences in this group.

An examination of ATSPPH scores through ANOVA failed to show any significant

differences (p = .073). A series of Kruskal-Wallis One-Way ANOVA tests

comparing different marital groups with the five helping sources also found no

significant differences between the divorced groups and others. Another series of Kruskal-Wallis One-Way ANOVA tests failed to show any differences between marital groups in terms of barriers to accessing mental health professionals. Finally, after creating a dichotomous grouping of married versus divorced respondents, a Mann-Whitney U test revealed that divorced respondents perceived significantly less confidentiality among all five helping sources than married respondents (p = .032). This finding may explain why more divorced respondents sought mental health treatment off base; that is, they did not believe that the military offered confidential help. Unfortunately, this conclusion does not explain why they believe they have less confidentiality.

Divorced respondents were more likely to have sought help than others, but neither attitudes toward help seeking nor perceptions of barriers gave adequate explanations for their behavior. These results may support the conclusions of others; that is, divorced individuals seek support in mental health counseling lost in their divorce (Horwitz, 1987; Veroff et al., 1981).

Years of Service and Help Seeking

Years of service seemed to have little, if any, relationship to help-seeking behavior. Members who had been in the USAF for long periods of time were no more likely to have sought help voluntarily (p = .441) or been forced to seek help (p = .772). Years of service, however, was positively correlated with a perception of barriers to accessing any type of help. The longer respondents had been in the USAF, the more likely they were to view seeking help from any source

as having a negative career impact, lacking confidentiality, and being embarrassing (Table 18). They were also more likely to distrust the abilities of these helping sources.

Years of service was not significantly associated with any of the barriers to accessing mental health providers but was associated with seeking help from others. New members of the USAF were more likely to have positive views of chaplains, friends, and physicians as helping sources (Table 19).

This analysis yielded a variety of significant results, but the correlations were low (Hinkle et al., 1994) and accounted for less than 10% of the variance in each case. Years of service was not a significant factor in predicting who would seek help from mental health professionals.

Air Force Service Codes and Attitudes Toward Help Seeking

An ANOVA comparing respondents' USAF service codes and their attitudes toward help seeking revealed significant differences (p = .004). The differences between these job categories were significant, but only those in the medical field (Category 4) appeared to be significantly higher than the other job categories (Table 20). Therefore, the variable AFSC was recoded into a dichotomous variable: medical versus nonmedical.

An independent t test using this new dichotomous variable showed that medical personnel had significantly higher or more positive attitudes toward seeking professional psychological help (p = .001). The medical respondents'

Table 18

Spearman Rho Correlations Between Years of Service and Barriers Across Helping Sources

Barrier	$\underline{N}$	r_s	r_s^2	$\underline{p}$
Question 1 (negative impact on career)	368	.1677	.0281	.001
Question 2 (lack of confidentiality)	368	.1255	.0158	.016
Question 3 (skill level of helpers)	368	.1238	.0153	.018
Question 4 (embarrassed to seek help)	368	.1553	.0241	.003
Question 5 (feel "weak" seeking help)	368	.0019	.0000	.971

Table 19

Spearman Rho Correlations Between Years of Service and Helping Sources

Helping source	$\underline{N}$	r_s	r_s^2	$\underline{p}$
Chaplains	368	.1666	.0278	.001
Commanders	368	.0269	.0007	.607
Friends	368	.2295	.0527	.001
Physicians	368	.1387	.0192	.008
Mental health providers	368	.0560	.0031	.284

Table 20

Analysis of Variance of Attitude Towards Seeking Professional Psychological Help
Scores by Air Force Service Code

Air Force service code	N	X̄	SD	F	p
1	91	24.21	4.78	2.872	.004
2	78	24.37	5.98		
3	93	24.98	6.25		
4	61	28.22	5.91		
5	10	25.05	4.84		
6	24	24.85	5.55		
7	1	Data unreliable			
8	6	25.33	6.02		
9	9	25.56	6.23		

mean score was 28.22 compared to nonmedical respondents' mean score of 24.64.

Further analysis of helping-seeking sources found that medical personnel were

more likely to view physicians (p = .001) and mental health professionals

positively (p = .007). In addition, they viewed mental health professionals as

providing more confidentiality (p = .020) and being more competent (p = .001)

than their nonmedical counterparts. They also viewed seeking help from a mental

health professional as being less embarrassing than nonmedical respondents

(p = .024). Finally, they were significantly less likely to believe that USAF

mental health professionals make a "big deal" out of small problems (p = .010).

These results suggest that medical personnel have substantially different views of

help seeking and barriers to accessing mental health services. Despite this positive view, medical personnel were no more likely to have sought mental health services than their nonmedical counterparts.

Research Question 4

Are there substantial differences between the attitudes toward help seeking of those who have voluntarily sought mental health services, of those coerced or forced to seek mental health services, and of those who have considered going but have not? What is the prevalence of USAF members who have sought mental health services from a civilian mental health provider? What are the attitudes and perceptions of those who have sought mental health service from civilian providers?

This section examines the characteristics, attitudes, and perceptions of various categories of help seekers and contemplators. A substantial percentage of the sample had sought services voluntarily or had been forced (Table 21). Slightly more than 9% had also opted to seek help from civilian providers.

This section looks at various groups in order to identify distinguishing characteristics. A word of caution, however; these groups were not independent of each other. In fact, several respondents indicated that they had sought help voluntarily, been forced, and gone off base.

Voluntary Help Seekers

Approximately 21% of the sample said that they had voluntarily used mental health services (Table 21). Comparisons with known military rates were unknown, but the percentage of USAF members who had voluntarily sought mental health treatment was comparable to rates in the civilian population (Link & Dohrenwend, 1980). A chi-square analysis found that women were more likely to seek help than men (p = .012), but because they make up less than one fifth of the USAF, more men sought help in this sample. Members with some college were also more likely to seek help (p = .020), which is consistent with studies of civilians (Olfson & Pincus, 1994b). Divorced USAF members were also more likely to be help seekers (p = .009), which is consistent with their civilian counterparts (Veroff et al., 1981). In addition, staff and technical sergeants were more likely than other ranks to have sought help voluntarily (p = .015). Not significant were years of service (p = .810), race (p = .204), and USAF duties (p = .352). For this analysis, race was dichotomized into Anglo American and non-Anglo American categories because of the few numbers in the Hispanic American and other categories. The AFSC was separated into medical and nonmedical groups for the same reason.

An examination of ATSPPH scores for the voluntary help seekers showed that they expressed a significantly more positive view of seeking psychological help than nonhelp seekers (Table 22). One shortcoming of this finding, however, is the question of whether or not they sought help because of their positive attitude or

Table 21

Frequencies of Voluntary Help Seekers, Forced Help Seekers, Contemplators, and Civilian Help Seekers

Variable	$\underline{N}$	%
Sought help voluntarily		
Yes	80	20.6
No	308	79.4
Total	388	100.0
Forced to seek help		
Yes	46	11.9
No	342	88.1
Total	388	100.0
Contemplators		
Yes	38	10.4
No	326	89.6
Total	364	100.0
Civilian help seekers		
Yes	36	9.3
No	350	90.7
Total	386	100.0

Table 22

Independent T Test Comparing Attitude Towards Seeking Professional
Psychological Help Scores Among Voluntary Help Seekers

Response	N	Sample %	X̄	SD	t value	p
Yes	80	20.6	28.70	5.81	6.50	.001
No	308	79.4	24.18	5.47		

whether or not seeking help changed their attitudes. This problem affected all of

the findings in this section with regard to attitudes toward help seeking. Still,

voluntary help seekers were remarkably similar to nonhelp seekers in all other

ways. For example, no single significant difference was found among the ratings

of the five barriers across all helping sources between these groups. In addition,

no difference was found between voluntary help seekers and nonhelp seekers in

their appraisal of barriers to accessing help from chaplains, commanders, friends,

physicians, and mental health professionals.

In an examination of barriers to accessing mental health providers, the

results were again surprisingly similar. Voluntary help seekers had more faith in

the skills of mental health providers ($p = .036$), but they were not significantly

different in their appraisal of the stigma associated with seeking help ($p = .486$),

lack of confidentiality ($p = .430$), or the negative effect seeking help could have

on careers ($p = .068$).

Overall, people who voluntarily sought help viewed seeking help from mental health providers more positively than those who did not, but they recognized the USAF norms against seeking help. These groups had distinct demographic characteristics in terms of gender, education, and marital status.

Forced Help Seekers

Respondents forced into seeking mental health services were indistinguishable from voluntary help seekers. Of the 12% who said that they were forced to seek mental health services, they were statistically of the same gender (p = .739) and race (p = .883) as those who had not been forced; they also had the same marital status (p = .250) and AFSC (p = .203). The only differences were in education and rank. Similar to those who voluntarily sought help, respondents with some college were more likely to be forced into seeking help (p = .028), and they were also more likely to be officers than enlisted (p = .001). Further analysis revealed that like those who voluntarily sought help staff and technical sergeants were most likely to be forced into seeking help.

Despite or possibly because of being forced into help seeking, these respondents did not have significantly different attitudes toward seeking help than the rest of the sample (as measured by the ATSPPH) (p = .299). They, however, were more likely to rate seeking help negatively from chaplains (p = .028), commanders (p = .022), and physicians (p = .002). No significant difference was

found in their rating of mental health professionals (p = .049).[1] They rated

friends no differently than nonforced help seekers (p = .203).

This group rated the five factors associated with help seeking higher than

those who had not been forced. Only feeling "weak" was significantly higher

(p = .004). The remaining factors were slightly above or below .05 but because

of repeated testing were not statistically significant. Their appraisal of the barriers

associated with seeking help from mental health professionals yielded similar

results; that is, they rated these barriers higher but not significantly higher. They,

however, overwhelmingly agreed that mental health professionals tend to make a

"big deal" out of small matters (p = .001).

This analysis of helping sources, barriers, and attitudes toward military

mental health professionals revealed that those forced into mental health treatment

have a negative view of seeking help in the military system. This view, however,

was not significantly different from the rest of the sample.

Little is known about those forced to seek help from mental health

providers. In actuality, the construct may be poorly defined. Some people wrote

that they needed to see mental health professionals for routine clearance matters,

whereas others indicated that they were forced as retribution from commanders or

first sergeants. These groups may hold little direct animosity toward mental health

providers or services but instead distrust the available help-seeking sources (except

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[1]Repeated testing required a correction to the significance level (Hinkle et al., 1994). A Bonferroni correction revealed that the result was insignificant.

for their friends). One problem with this analysis is that respondents were on active duty. A survey of former USAF members, who may have been discharged in conjunction with being forced into mental health services, may have yielded different results. Overall, however, this group was demographically indistinguishable from the rest of the sample (except for rank and education).

Contemplators

Another group that was demographically indistinguishable from the sample were people who contemplated seeing a military mental health professional but had not. The question in the survey was poorly worded. As a result, people who had gone for help answered it affirmatively. I recoded responses in order to identify people who contemplated seeking help but had not. This group was statistically indistinguishable from the sample in terms of AFSC (p = .192), marital status (p = .429), rank (p = .688), race (p = .576), or gender (p = .908). Contemplators were more likely to have college degrees than the rest of the sample (p = .021).

Contemplators had distinguishing characteristics in terms of attitudes and perceptions. For example, they had significantly higher scores on the ATSPPH than noncontemplators (p = .019). Contemplators rated all helping sources more negatively, but only their responses concerning chaplains were significant (p = .003). An examination of barriers with all helping sources revealed that contemplators were more likely to view asking for help as negatively affecting careers (p = .027) and less confidential (p = .007) than noncontemplators. These

barriers appear to be the primary reasons they avoided help seeking from mental health professionals. In a comparison of the barriers to accessing mental health services, their responses were statistically indistinguishable from the rest of the group.

The contemplator group appears prone to seek help but not in the military system. In fact, they are more likely to have sought help from civilian mental health providers than others in the sample ($\underline{p}$ = .001).

Civilian Help Seekers

Of all the groups discussed in this study, the least information seems to be known about USAF members who sought help from civilian mental health professionals than their base mental health clinic. More than 9% of this sample admitted going "off base" for help; in fact, the actual number may even be higher (Table 21). One respondent wrote, "I would not have responded if my answer to #21 was 'yes.' Even with your assurances that this survey would be 100% confidential, I personally would not have taken the chance." One respondent merely wrote "N/C," suggesting he had sought help but did not want to comment. Still, the 9% finding was surprising given the fact that USAF members have free care available on base but probably must pay for it off base. There are circumstances, of course, in which active-duty USAF members might not have to pay for care. For example, if their spouse has health insurance, the active-duty member may be covered. Still, the question was asked if they had gone to a "civilian mental health professional because you didn't want to go to the base

mental health clinic," which should have focused their attention on avoiding base services more than having the opportunity to go off base.

From a demographic standpoint, this group was virtually indistinguishable from the rest of the sample. No statistical differences were found in terms of AFSC ($p = .962$), education level ($p = .073$), rank ($p = .175$), or race ($p = .839$). One difference was that this group was more likely never to be married ($p = .001$).

Similar to those who have gone to military mental health providers and contemplators, civilian help seekers had more positive views of help seeking, as measured by the ATSPPH ($p = .001$). On the other hand, no significant differences were found between their attitudes toward the different helping sources and those of the rest of the sample. Likewise, no differences were found in their assessment of the barriers across helping sources. When examined separately, noncivilian help seekers and civilian help seekers were no different in their appraisals of barriers to accessing mental health professionals. In fact, civilian help seekers were less likely to state that military mental health professionals make a "big deal" out of small problems ($p = .030$). Question 16 of the MATS may explain civilian help-seeking behavior. For this question ("The USAF has plenty of help for me if I have any personal or emotional problems"), civilian help seekers were significantly more likely to disagree with this statement ($p = .017$).

Overall, despite civilian help seekers engaging in unique behavior, they were no different than noncivilian help seekers but may have been unaware of

available services. Incidentally, this study assumed that USAF members have

access to care. In the next section, this assumption is examined with regard to

some of the comments received on the surveys.

Multiple Linear Regression Model Predicting Attitude Towards Seeking Professional Psychological Help Scores

Table 23 summarizes the key finding for each category of help seeker.

These profiles indicate broad generalizations concerning who will and will not seek

help, but it does not provide a concise indication of who may need further

information concerning mental health services.

In order to identify which groups would benefit from information

concerning mental health services, a multiple regression model was computed.

This model examined the relationship between ATSPPH and a variety of

demographic and perceptual barriers. ATSPPH scores were selected because

voluntary and civilian help seekers consistently scored higher than nonhelp seekers;

contemplators also scored higher. The ATSPPH has not been shown to predict

actual help seeking (Fischer & Farina, 1995), but certain populations who have

scored high on the ATSPPH do have higher incidences of seeking help from

mental health professionals. Women in this sample had higher ATSPPH scores

and were more likely to have sought help, which is consistent with previous

research (Fischer et al., 1983; Johnson, 1988). In addition, USAF members who

sought help voluntarily in this sample were more likely to have some college than

any other educational category, which is consistent with findings among civilians

Table 23

Summary of Significant Distinguishing Demographic Characteristics, Attitudes, and
Perceptions of Barriers Among Voluntary Help Seekers, Forced Help Seekers,
Contemplators, and Civilian Help Seekers

Group	Characteristics	p
Voluntary help seekers	Higher Attitude Towards Seeking Professional Psychological Help scores	.001
	More likely women	.012
	Some college	.020
	Divorced	.009
	E5-E6	.015
	Barrier (positive appraisal of mental health providers' skills)	.036
Forced help seekers	Some college	.028
	Enlisted	.001
	Negative view of chaplains	.028
	Negative view of commanders	.022
	Negative view of physicians	.002
	Barrier (feel "weak")	.004
	Barrier (mental health professionals make a "big deal")	.001
Contemplators	Higher Attitude Towards Seeking Professional Psychological Help score	.019
	College degree	.021
	Negative view of chaplains	.003
	Barrier (negative career effect)	.027
	Barrier (lack of confidentiality)	.007
Civilian help seekers	Higher Attitude Towards Seeking Professional Psychological Help scores	.001
	Never married	.001
	Divorced	.001
	Mental health professionals make a "big deal"	.030
	Lack of available help	.017

(Olfson & Pincus, 1994b). Therefore, the ATSPPH may be a good indicator of who will seek help and, more importantly, who will not seek help.

Demographic factors were entered into the multiple regression equation. Since multiple regression relies upon continuous or dichotomous variables, some recoding was necessary. A dichotomous variable separating medical versus nonmedical fields was used. In addition, the marital variable was made into three dichotomous variables, separating married, divorced, and never married. Race was separated into Anglo American and non-Anglo American categories. Two education variables were used. One variable separated those with "some college" from the rest of the sample. Another variable separated those with college degrees and higher from the rest of the sample. Finally, gender (male versus female) and rank (officer versus enlisted) were entered.

Some barriers also were included in the equation. The total barrier perception for each helping source was added. This step was performed to determine whether or not respondents' perceptions of other helping sources influenced their attitudes toward mental health services. Finally, responses concerning the perception of the availability of services and whether or not USAF mental health professionals overdiagnose were also included.

A stepwise solution was used. Stepwise solution allows each variable to be reassessed after entering the equation and overcomes the problems associated with forward and backward solutions (Munro & Page, 1993). Table 24 shows the results of this analysis. The most significant factor associated with ATSPPH

Table 24

Stepwise Regression of Independent Variables and Attitude Towards Seeking
Professional Psychological Help Scores

Variables	Beta	Multiple r	r^2	t	p	F	p
Gender	.1661	.57	.33	3.31	.001	43.21	.001
Never married versus married/divorced	-.1172	.60	.36	-2.41	.017		
Barriers to military mental health professionals	-.2129	.62	.38	-3.94	.001		
Overdiagnosis by military mental health professionals[a]	-.4262	.63	.40	-7.65	.001		

[a]Response to MATS (Question 17) that asked respondents whether or not they believed that military mental health professionals make a "big deal" out of small matters.

scores was gender, accounting for one third of the variance in scores. Again, women had more positive scores than men. Single respondents, however, had more negative scores. As might have been expected, the perception of barriers to military mental health services was also a significant predictor of an ATSPPH score. The perception that USAF mental health professionals overdiagnose was also a significant predictor.

Despite these findings, the model accounted for only 40% of the variance in ATSPPH scores. This result may indicate that other factors not captured in the MATS may account for the ATSPPH score. Still, the results indicate that single males may have the most negative attitude towards help seeking and be the most likely targets of education concerning mental health matters.

Analysis of Comments

One of the most surprising parts of the study was the number of

respondents who made comments at the end of the survey. One hundred twenty-

one (31%) respondents wrote comments. Many of these comments were short

statements, but others were extensive. One respondent typed more than a page of

comments concerning mental health services and the USAF. The results of an

analysis of these comments are presented in this section. In the first part,

comments concerning the importance of this study are examined. In the next part,

comments pertaining to the five factors or barriers are presented, as well as their

opinions concerning the different helping sources. Finally, some respondents

suggested ways to improve access to mental health care for USAF members.

This analysis has a qualitative flavor. Qualitative research, however,

requires depth and detail (Guba & Lincoln, 1994). The comments of anonymous

respondents on the back of the survey appear to lack these characteristics, but they

do provide a further glimpse into the attitudes of USAF members toward seeking

mental health care. For clarification, many of the respondents used the term

"mental health" when referring to seeking help from mental health providers.

Importance of the Study

This study seemed to strike a nerve for many. Five respondents made

specific comments. One officer simply stated that this "seems like an important

study," whereas another said the study was "extremely important" (which she

knew from personal experience). Prior to being a member of the USAF herself,

she was married to an active-duty member. When they started to have marital problems, "He absolutely refused to go to mental health services on base. No way, no how! . . . He would only go to civilian counseling with me and not alone." The marriage ended in divorce. A noncommissioned officer took a broader view but expressed a similar opinion. He said, "Our military has grave emotional, physical, psychological, and spiritual-related problems. . . . This survey is a glimmer of light that shall shine on a bigger problem." Not all of the comments were encouraging. One senior officer wrote, "Perhaps you could think of more pertinent surveys."

Barriers to Help Seeking

Respondents addressed the five barriers identified in the literature review. They also made comments on the other factors, which were not addressed in the MATS. One senior noncommissioned officer, who had sought help in the civilian sector, seemed to sum the comments of most. He wrote, "Anyone seeking help from a military mental health 'professional' is insane." He then listed three reasons, "Career repercussions—poor quality of 'help'—lack of confidentiality."

Negative Impact on Career

The factor career repercussions was on the minds of most respondents. Twenty-four respondents said that seeking mental health services could be detrimental to their careers. One senior officer in his 30s wrote, "What a great way to end your career." A junior officer echoed the same sentiment, "The

bottom line is, if you seek military mental health care, it will hurt your career. Let's be honest about this." An airman wrote, "Military mental health will only ruin your career."

The negative career impact concern appeared to be especially important for people with special security clearances. AFI 31-510 mandates starting a "special security file" on anyone who has a mental or emotional illness that "may cause a significant defect in the person's judgment or reliability" or if alcohol abuse "results in impairment of an individual's ability to perform assigned duties or to adequately safeguard classified information" (p. 16). A special security file is the initial documentation necessary for later administrative or adjudicative actions and necessarily means a security clearance is denied. These closely worded rules appear to be prudent and not overly discriminatory given the sensitive nature of Department of Defense duties. In practice, however, the application of these rules may not be prudent or at least the perception by potential help seekers is that the "real" rules are much more restrictive than they appear in the regulation. One airman wrote, "The problem with mental health is if you go, so does your clearance. . . . [Seeking mental health services] is the kiss of death for anyone with a clearance." A junior officer commented that he would "never consider seeing a military mental health professional" because it would jeopardize his security clearance. One respondent summed the opinion of many with a short comment, "Get counseling = lose security clearance!" In order to support this opinion, many pointed out that security clearance questionnaires ask about having

sought mental health treatment.

One female officer in her 30s wrote that she had sought treatment for depression and, in fact, had had her clearance pulled. She, however, said this action was only temporary, and she was thankful to have gone for help. She did not indicate that her career was damaged, but she did acknowledge the broad perception that people with special security clearances "don't dare set foot" in a mental health clinic.

Another group, which seemed particularly sensitive concerning help seeking, was aviators. A junior officer in his 20s wrote that seeking help "would kill an aviator's career." Another flyer commented, "I definitely would fear that mental health counseling would adversely affect my flying career. . . . I would love to have the mental health option; however, I would never use it if I thought there was any chance of it damaging my career."

Other respondents believed that seeking mental health services was acceptable but only for enlisted members. A help-seeking officer said, "Mental health [counseling] is fine for enlisted ranks but not for officers." Another junior officer, implying a similar standard, wrote, "Like it or not, going to mental health is still viewed as 'career death' in the officer ranks."

Many respondents commented that they had actually witnessed the negative effects of help seeking. A female airman in her 20s said that she had personally seen several people's careers ruined. A senior noncommissioned officer, who had been in the USAF more than 21 years, wrote, "Those few instances of which I am

aware where people have dealt with mental health have all been negative." A senior officer, who had sought help from a civilian provider, wrote that he had "personally seen the military mental health service abused by senior officers when they had disagreements with junior officers."

Another senior officer tried to seek help for members of his squadron; it "backfired." "One voluntarily submitted himself for alcohol counseling, and he spent months trying to keep his flying status," he wrote. He concluded, "I would not recommend mental health counseling or drug/alcohol abuse counseling unless it was as a last resort because of the ramifications to the individual's career." This commander appeared to be genuinely concerned for the well-being of his personnel; but he also displayed a naiveté concerning mental health problems, especially those related to alcohol abuse.

Many respondents indicated having seen other people's careers adversely affected by having sought help, but no one said that their careers had been adversely affected. Some did say that their experiences were negative. For example, a junior officer said, "I was recently harassed for seeking mental health services for depression. A flight surgeon recommended I be medically boarded without ever having met me or checking my performance. I have never missed a day of work due to depression, and my performance was very good."

On the other hand, many seekers praised mental health services. A junior officer wrote, "I've had no negative repercussions from my past counseling experiences." A commander wrote, "I have sought professional mental health

counseling on three occasions, and all three were extremely beneficial in improving my mental health." She encourages all of her subordinates to use these services. Another commander said he had sought help and learned "to deal with his problems much better now than before."

Lack of Confidentiality

From the remarks, the second most prominent reason USAF members avoided mental health services was the lack of confidentiality. Fifteen made comments. These comments were negative; that is, the USAF mental health system did not offer confidentiality. A junior officer said, "USAF members do not like visiting mental health professionals mainly due to the lack of confidentiality." Another junior officer wrote, "With no assurances of confidentiality, there is no way that I would ever seek help from a military mental health provider." A junior officer, who had been forced to seek help, wrote, "Whatever the party line, I know that military mental health professionals and military doctors are not bound to confidentiality. I would never voluntarily seek AF [Air Force] mental health services."

Two of the respondents expressed that distrust of the mental health professional's loyalty was the threat to confidentiality. One senior officer, who had contemplated seeking help, wrote, "It is impossible for mental health professionals to serve both the needs of the Air Force and the needs of the individual at times." Similarly, an airman remarked, "Mental health professionals have an obligation to the USAF, not to the participants." One junior officer

simply viewed USAF mental health services as an instrument to monitor USAF members. He wrote, "Mental health is necessary for the management of the force. I sometimes have reason to doubt the 'loyalty' of some mental/physical health professionals. If indeed it is mission before people, are they going to give me the care I need or just enough to keep me a 'warm body.'"

The fear most expressed, however, was not that mental health professionals would directly divulge information to others but that the content of therapeutic sessions would be recorded in medical records. One senior officer, who characterized USAF mental health services as a "joke," pointed out that USAF members' medical records are government property. "You can't even take them when you separate or when you retire. Confidential? 'Give me a break.'" Members, of course, can obtain copies of their medical records. Another senior officer complained that USAF mental health records have a reputation for being nonconfidential and that unscrupulous and ill-informed commanders misuse this information. He remarked, "The fear isn't mental health . . . but these commanders."

Unfortunately, none of the respondents explained exactly how commanders gain access. A young married airman in his 20s gave some hint, "There is no 'privacy' or 'confidentiality' in the military only a 'need to know.' If conditions warrant a 'need to know,' your confidentiality will be compromised!" As indicated in the literature review, this "need to know" covers several areas. Still, only 1 respondent gave a specific example in which he believed confidentiality was

breached. For example, therapy notes are kept exclusively in mental health, with short entries made in the general medical records to which many hospital personnel have access. In this case, the respondent was upset that material pertaining to his divorce was included in his medical record. He wrote, "If my divorce stuff could get into my medical records, then anything else that I would/could talk about would also be in there—[go back to mental health] no way in hell." Even this "breach," however, did not appear to result in his commander discovering any information, suggesting that the fear of information disclosure is high but that the incidences may be low.

One senior officer, who had sought help from a civilian provider, probably offered more prevalent problems with confidentiality. She wrote, "Unfortunately, even if mental health professionals maintain confidentiality, you still run the risk of highlighting yourself simply by sitting in the waiting room at the base hospital. I do not want to chance being labeled 'unstable,' and so I avoid military providers to limit my exposure." This comment, of course, speaks as much to the stigma associated with help seeking as to the lack of confidentiality in the military mental health system.

As a result of the lack of confidentiality, many respondents indicated a preference to seek help in the civilian community or from chaplains. A junior officer who had sought help from military mental health providers said, "Confidentiality is not as secure as with a Catholic chaplain. I would rather work an issue out with a priest." He also commented that he would talk to mental

health professionals about "noncareer threatening problems" but not "major"

issues. Another junior officer said that he preferred to send people to chaplains

because of the lack of confidentiality. This barrier also caused one chaplain to

encourage another junior officer to seek help for depression from a civilian

provider.

Skills of Mental Health Providers and Other Helpers

The lack of confidentiality is not the only reason that many USAF members

avoided seeking help. Many members did not place much faith in the abilities of

military mental health professionals. One noncommissioned officer wrote, "Quite

honestly, I don't have much faith in military Dr.'s [sic] or physician assistants. So

when it comes to mental health Dr.'s [sic] or persons, they fall into the same

category." Another noncommissioned officer wrote, "I don't put allot [sic] of

stock in military mental health professionals, whether physical or mental."

These comments seem matter of fact, but other comments were even more

emphatic. A noncommissioned officer forced to seek help said, "Do military

'doctors' have malpractice insurance? No? Then they must not be real doctors

huh? I do not like being used as a guinea pig for some third rate doctor who could

not hold down his job on the outside." He added, "Anyone you see in uniform

will probably feel the same way." Military "doctors," of course, are "real

doctors," and mental health professionals must experience credentialling processes,

but this respondent's perception was not unique. Another noncommissioned

officer, who had not sought help, wrote, "The so-called 'mental health professionals' usually are trainees or on-the-job training." Again, this perception is untrue but suggests that it may be a popular misconception.

Another perception was that mental health services, in general, are suspect and, in fact, other alternatives are better. A junior officer wrote, "My feeling is that I have little to no confidence in the effectiveness of traditional mental health care (not just Air Force). I think a chaplain or someone like Tony Robbins (who focuses on results rather than diagnosis and treatment) could be more effective at making positive changes in a person's life." Another junior officer seemed to believe that mental health services allow people to avoid rather than to accept their responsibilities. He wrote, "My family believes that many people overuse mental illness as an excuse for nonperformance. People should be forced to take responsibility for their actions even if they have an excuse."

Not all of the comments were negative. One commander wrote, "In my short career in the Air Force to date, I have gotten positive feedback regarding the services chaplains and medical [mental health] professionals provide." Another officer simply wrote, "Good people, effective system. . . . Well done." Still, negative responses continued to outnumber positive responses three to one.

Where do USAF members prefer to seek help? Clearly, the most popular answer was chaplains. "I would be much more likely to seek help in a church or Christian environment. In fact, most of my problems I take directly to God," wrote one officer. A young airman wrote, "The chaplain would be the greatest

help for myself because I have a strong faith in God. More people need to have that kind of faith and put their problems in God's hands."

Many of the comments suggested that religious faith prevents mental health problems or more effectively ameliorates personal problems. "I am a born again believer and rely on my Lord and savior Jesus Christ, so I don't have these kinds of problems," wrote one field-grade officer, adding, "Read your Bible more." This religious inclination also seemed to prevent some members from considering mental health services. One teenage airman wrote, "I put my faith in God to get me through my problems. I have been brought up not to 'tell the world' about my personal problems."

For these respondents and others, mental health services seemed to be only a last resort and then only for "bizarre problems." A field-grade officer, with more than 15 years of service, wrote, "While there are extreme cases in our society (e.g., child abuse, spousal abuse), many, if not most, personal problems could be lifted to a large degree through work, productive hobbies, prayer, adherence to sound principles (such as gospel principles). Having said that, undoubtedly some people's situations are bizarre enough to require professional help." An airman saw mental health as the last stop when confronted with problems, "Professional help should be a last resort, because friends and family will have more support for the individual in need. If friends and family can't help and this person has no faith in God to get him through, I feel professional help should be a must." He added, though, if he went for help himself, he would be

"scared that [his] friends might find out."

Stigma of Seeking Help

The stigma associated with help seeking was another common theme among

the respondents, but the stigma they discussed always concerned mental health

problems within the military environment. One senior enlisted man wrote,

> There is still a very definite stigma attached to mental health in the
> Air Force. . . . The baggage that goes with mental health prevents
> most supervisors, individuals, and loved ones from referring or
> seeking help there at the early stages of problem development. By
> the time a referral is "mandated" for an affected person the extreme
> behavior that predicted it has all but alienated the closest loved ones;
> it also makes the mental health services almost exclusively reactive.

One junior officer sought civilian help because "the stigma associated with going to

a MH [mental health] professional on base and being seen by someone I know

absolutely terrified me." Another civilian help seeker wrote, "I had strong fears

of being rejected by others who felt I was a 'psycho.' Although I now realize this

was a rather naive view, it was still a major concern."

A middle-grade enlisted man who had sought services in the civilian

community and on base wrote that the perception in the USAF is to

> never, never tell anyone you work with in the military you went to
> mental health, you will be a social outcast. I feel it starts with
> society. The general public wants a strong mentally fit fighting
> person in the armed forces, and there is no room for anything else.

Another airman who had sought help on and off base blamed the USAF leaders for

accepting societal norms. He wrote, "Unfortunately, there is a stereotype that

goes along with mental health. There are a lot of commanders and first sergeants

that believe the stereotypes. If I am crazy for going to mental health, then call me crazy!"

Lack of Help

Three of the respondents indicated that the USAF does not provide enough mental health support or does not adequately advertise available services. One junior officer, who was taking an antidepressant but wanted to stop, wrote,

> The Air Force doesn't have enough mental health personnel, so it's difficult to make an appointment. This is complicated by the lack of psychiatrists. Medications are used so much anymore, but the psychologists won't or can't answer my questions on the medication I'm taking. The medical doctors who prescribe it also are hesitant about answering my questions. There doesn't seem to be anyone on this base who can evaluate both the mental and physical components of [my] problem.

One airman, who had voluntarily sought help, wrote, "I think mental health facilities should make themselves better known and available to all levels of AF [Air Force] personnel. A lot of airman of lower rank status aren't aware of the help that is out there." Another middle-grade noncommissioned officer added, "I feel there is not a lot of information out on the streets on how mental health can help us." A good example of this problem was an airman in her 20s who may have been suffering from postpartum depression. She wrote, "I would have really liked to talk to someone after my second child was born but did not know where to go and get the right help."

Some respondents who knew where to get help could not access the system. A junior officer wrote, "I called once about a divorce problem, but they were too

busy and could not fit me in their schedule. They never called back." One officer

said that she suffered a variety of physical problems diagnosed as stress related.

She was unable to get an appointment for 1 week at the base mental health clinic.

Before that appointment she became so scared and sick she checked herself into a

mental health ward. She found some relief but is still having problems. She

reported that there was no coordination between her physical and mental health

providers.

> Now I can't find anyone at our clinic who is able to give me solid
> guidance on whether to stop the antidepressants and how to go about
> doing it safely. I'm starting to think about going off base to get
> some help. . . . If I had gotten the right help when I originally
> asked for it, I don't think I would have had as many problems later
> on.

One problem might have been the hours open for help. A noncommissioned

officer complained that mental health services follow a "9 to 5" schedule; but most

of the USAF works different shifts, which makes getting an appointment more

difficult.

Seeking Help in the U.S. Air Force

Many of the respondents commented on the norms associated with help

seeking in the USAF. All of the identified barriers played a part in their

assessment, with some respondents identifying a new barrier. This barrier appears

to be a systematic resistance to help seeking. In other words, the USAF system

discourages people from help seeking. This discouragement comes in the form of

commanders and first sergeants who are unsympathetic to members with problems

and who punish those who seek help.

Unsympathetic leadership was highlighted in a comment from a junior officer. He wrote, "I've seen a bigger problem with supervisors who are unsympathetic or totally unaware of subordinates' stress and fail to offer support." He added, "Not acknowledging a subordinate's stress may be the straw that breaks the camel's back." Several respondents noted that commanders and supervisors encourage people to get help or at least take time for themselves, but they often fail to support those seeking help. "They sometimes tell you it's okay to get help," wrote one noncommissioned officer, "but then when you take time from work it's not okay." A junior officer commented, "A commander may openly encourage time off and recreation, but when approached about it, the commander refuses."

A middle-grade noncommissioned officer claimed that he had seen his peers' performance reports suffer because they sought help. He wrote, "For the most part, people feel reluctant to get counseling because immediate supervisors hold it against people." He continued that help seekers are not "perfect" and that the USAF is looking for perfect people. This comment seems consistent with Dunivin's (1992) analysis of the combat masculine warrior paradigm and military culture. People who seek help are acting differently than the paradigm dictates. Having problems in themselves may also be inconsistent with the culture, which explains the comments of this noncommissioned officer. He wrote that the USAF culture is uncomfortable with mental health problems, "People don't want to hear

about it, commanders don't want people with mental health problems." He believed that this is the reason many like him have sought help off base. Another airman wrote, after the death of two family members, that he was encouraged to seek help but not from mental health. Still at work, his duties were restricted, which made him feel like a "malfunction" sign had been posted: "This individual is no longer an asset or contributor but is extra baggage."

Not everyone's appraisal was negative. One noncommissioned officer with more than 15 years of service reported a change in mental health services during his career. He wrote, "In the past, it was a witch hunt, and supervisors and hospital staff were out to find any and all witches; now they seem to be on the side of the member to help them and make them more productive so they can return or stay in the work force." Given the substantial perception of barriers to accessing mental health services demonstrated in this chapter, this opinion may be in the minority.

Good and Bad Experiences in the Military Mental Health System

Many respondents talked about their experiences in the military mental health system. These experiences did not necessarily speak to barriers of accessing services, but they did show unique aspects of seeking help in the USAF system, and they were especially useful in understanding why so many seek help off base.

One senior officer wrote that the reasons he sought help off base were that providers were more experienced, he did not want the stigma of being seen at the

base mental health clinic, and it was easier to schedule an appointment off base.

Another officer sought help off base after experiencing little success on base. He

wrote,

> I spent 2 years working with severe depression and deep emotional
> fears with military psychiatrists. Eventually I paid out of my own
> pocket to see a very experienced off-base psychologist. . . . I felt
> MUCH more comfortable opening up to and seeing a civilian
> counselor. Most, if not all, concerns I had been working for 2 years
> were resolved in about 3 months.

These civilian help seekers believed that they received more competent care off

base. In particular, the second respondent credits his quick recovery with their

expertise. One point that may have eluded him is that since he was paying for

every visit he may also have been more motivated to work harder at his problem.

The research on this point is not definitive, with some psychotherapists insisting

that clients who pay for therapy directly are more highly motivated than those

whose fees are paid for by insurance or grants (Garfield, 1994). Another help

seeker highlighted the closeness of the USAF community as her reason for seeking

help from a civilian provider. She went off base because she "knew the base

psychiatrist from other professional settings."

Respondents forced to seek help gave interesting, yet short, comments

concerning their experiences. The brevity of these responses seemed to spur more

questions that could not be answered. Still, they provided insights into this

process. An obviously upset noncommissioned officer believed that he was

unfairly forced to receive treatment from mental health providers. He wrote, "I

don't believe military personnel should be forced to see a mental health

professional for having an argument. Do you?" A field grade officer, who was almost ordered to seek help, wrote, "Almost forced to have a 'command directed' MHE [mental health evaluation]—at the whim of a vicious supervisor—where does one go for help with a supervisor? A horrible experience?" Another senior officer claimed that everyone in her office was forced into seeking help. "I worked in a high stress office for 3½ years," she wrote, "and everyone was ordered to go see the mental health doctor." All of these comments were intriguing, but they raised even more questions than they answered. Future researchers may want to look at forced help seeking more closely.

Suggestions for Improvement

Among reports of experiences and perceptions of barriers, many suggestions were made to improve the system. Suggestions are discussed in the next section, with comments from the respondents being helpful in identifying areas for analysis.

One suggestion, which has been tried at various bases, was to rename the mental health clinic to something more positive. An officer wrote,

> Name the centers something other than "Mental Health." Family or
> Personal Improvement Centers would bring less negative images to
> the forces as a whole. Make it sound like your [sic] taking positive
> steps to improve difficulties in your life. Being 'mental' is not
> something one brags about.

A young airman concurred with this sentiment. He wrote that the term "mental health" flashes images of "One Flew Over the Coo-Coo's Nest," suggesting, "Maybe a good start would be to change the title to transitional management or

assertive reinforcement center." Possibly suggesting the potential hypocrisy of this change or at least his own negative view of mental health services, he added, "Any ambiguous, false advertising title should do."

Many respondents believed that mental health services tend to be reactive rather than proactive. "Mental health needs to take a proactive charge forward by attending commanders' calls, enlisted and officer calls. Maybe attending a security forces guardmount and giving a brief summary of who they are and how they [mental health] can assist," wrote a noncommissioned officer. A medical officer believed that USAF members should have an annual mental health checkup just like a physical checkup. Another medical officer wrote that all USAF members should be ordered to attend classes on substance abuse, family violence, and stress relief.

Removing the stigma associated with mental health counseling was suggested by many of the respondents, but few offered specific advice. One senior officer suggested that mental health take a more health-promoting and less problem-diagnosing position. He wrote,

> If military MH [mental health] can develop programs that can focus
> on improving existing performance, then it seems this could do
> much to remove the stigma associated with MH counseling. One
> example would be to develop MH libraries with books and
> audiotapes and possible courses on psychological leadership.

Another officer had a similar comment. He wrote,

> If military MH [mental health] can develop programs that can focus
> on improving existing performance (for managers, for example),
> then it seems this could do much to remove the stigma of mental
> health counseling.

An officer who lost a military friend to suicide said nothing about the stigma associated with help seeking or any of the other barriers. Her concern was that because of the drawdown the USAF has been permeated by more individualistic and self-reliant attitudes, which have hurt those in need. She wrote, "Being in the military used to mean that you were part of a big family. But I think we're moving away from that, and it is creating a very lonely feeling for some people. If you really want to do something about the depression rate in the military, start at the absolute top and try to instill a sense of family."

Some respondents did not believe the system could be reformed. A senior officer concluded, "All military mental health matters should be contracted out." In other words, military personnel should be allowed to seek civilian mental health care at the expense of the military.

CHAPTER VI

DISCUSSION

In both of the results sections, there is ample evidence to support the conclusion that substantial attitudinal and perceptual barriers exist that prevent active-duty USAF members from accessing mental health care. In this section, the key results are summarized and discussed, and the theoretical perspectives used in the literature review are applied. Finally, recommendations to improve access are proffered, as well as limitations of this study and suggestions for future research.

Summary of Key Findings

The literature review demonstrated that there are substantial mental health needs among USAF members. The review also showed that utilization of mental health services by USAF members is low, perhaps even lower than in the civilian community. The review suggested that barriers to accessing services may explain this phenomenon, but it also showed that no comprehensive study had been conducted to help identify these barriers. This study showed that there were at least five attitudes or perceptions that USAF members hold that may prevent them from accessing mental health services: (a) fear that seeking help will negatively affect a member's career, (b) a lack of confidentiality offered in the USAF mental health system, (c) a negative perception of mental health problems and services,

(d) a military cultural bias against help seeking, and (e) a lack of knowledge concerning available services.

The first research question asked whether or not there were significant differences between the help-seeking attitudes of USAF members and civilians. A comparison was limited, but the results showed that the USAF members in this sample had significantly less positive views of help seeking than civilians. As a result, the low rate of utilization may be accounted for through distinctively negative or neutral attitudes toward seeking help. This result was confirmed in the survey response section by a number of comments that characterized mental health services and providers negatively.

The second research question examined various barriers and their relationship to different helping sources. This analysis showed that the sample agreed that there were more barriers to accessing mental health providers than to any of the other helping sources.

The second research question also had several subquestions that examined each of the five barriers identified in the literature review. This analysis showed that USAF members believed that talking to mental health professionals and commanders about personal problems was equally detrimental to a military member's career. This result was somewhat surprising, given that mental health professionals have no direct authority over their patients and are trained to help (not hurt) their clients.

The results also showed that USAF members perceived greater confidentiality when talking to chaplains than any other helping source. In terms of confidentiality, the sample saw no difference between talking to a mental health professional and talking to a friend, despite USAF regulations and mental health codes of ethics safeguarding confidentiality.

This study also indicated that chaplains were perceived as being more qualified to help people with personal problems than mental health professionals. Surprisingly, the sample also reported no significant difference in their appraisal of mental health professionals' skills to solve personal problems and those of friends, commanders, or physicians.

In terms of the stigma associated with help seeking, the results clearly showed that there is more stigma attached to seeking help from mental health professionals than from any other helping source. In addition, USAF members felt "weaker" seeking help from mental health professionals than from any other source. In fact, for both of these variables, respondents indicated that "embarrassment" and "weakness" were attached to seeking help from mental health professionals but no other sources.

The comparison of these first five questions examining mental health providers only revealed that embarrassment and weakness were the most significant barriers to accessing their services. All of the factors were noted as barriers, but the stigma attached to seeking help was the most significant reason USAF members avoid it.

Whether or not USAF members are aware of services available was less clear. The results indicated most believed that "there was plenty of help available to them for personal problems" (Question 16), but a substantial number did not agree. Several people made comments that mental health services are not widely advertised but are widely stigmatized. Question 16 in the MATS may have been too vague to access this factor accurately. Comments on the survey suggested that some who had tried to access care found services to be lacking. Because most respondents had not sought help, perhaps they have been unaware of services available to them. In other words, they may have a general perception of services being available but never tried to access them.

The third research question examined differences between groups within the sample. The most distinct grouping within the sample was between officers and enlisted members. The results showed that officers were significantly less likely to have sought help voluntarily or been forced to seek it. Unfortunately, there were few explanations of this difference. One possible explanation is the unwritten norm that prohibits officers from seeking help, which is greater than that for enlisted members. The differences between men and women in the study were easier to understand. Women were more likely to have sought help, and they also had more favorable attitudes toward seeking help—down-playing the significance of barriers to accessing mental health care. These results are consistent with other research. This study also showed that medical personnel were more likely to have favorable attitudes toward help seeking, but their rate of help seeking was not

significantly different.

The final research question addressed the characteristics of various types of help seekers. Approximately 9% of the sample had sought help from a civilian mental health provider, 12% had been forced to seek help, and 21% had sought help voluntarily from a military mental health provider. Few differences were found between these groups, but those who had sought help from civilian or military mental health professionals had more positive attitudes toward seeking professional psychological help. The survey responses indicated that some who had been forced to seek help were particularly bitter from their experiences. Those who had contemplated seeking help but not acted had significantly more fear of negative career impact and lack of confidentiality than the remainder of the sample. Those who had sought help from a civilian provider were less likely to agree with Question 16 of the MATS ("The USAF has plenty of help . . . for personal problems").

Overall, the results from this sample indicate that there are significant barriers to accessing mental health services in the USAF. This study clearly shows that seeking help from mental health providers is considered detrimental to the careers of USAF members. The system is perceived as providing little, if any, confidentiality. USAF members are also surprisingly neutral in their assessment of the skills of mental health professionals and seeking help.

Theoretical Analysis of Results

Three theoretical perspectives were used in the formulation of this study: (a) attitude, (b) common sense, and (c) rational theories. Each of these perspectives highlights differences in the results as possible explanations for the low use of mental health services among USAF members.

Attitude Theory

Fischer and Farina (1995), as well as others (deBarot, 1977; Fischer & Turner, 1970; Fischer et al., 1983), posited that attitudes toward help seeking play a large but not exclusive part in the decision to seek professional psychological services. From the results of this study, USAF members may have substantially more negative views toward seeking help than civilians. As indicated by their ATSPPH scores, they have a neutral attitude towards seeking help as a whole. As the survey responses showed, many in this sample were adamantly opposed to even the idea of seeking mental health services. From an attitude theory perspective, the USAF's rate of using mental health services is low. Their negative attitudes toward help seeking predispose them to avoid formal help seeking or to rely on other sources. One problem, of course, with this conclusion, which is primarily based upon ATSPPH scores, is that these scores have never been shown to predict help-seeking behavior (Fischer & Farina, 1995). Another problem is that attitudes, in general, may be poor indicators of future actions (Petty & Cacioppo, 1981). Still, these negative attitudes, when coupled with other results, may partly explain help-seeking behavior among USAF members.

Common-Sense Theory

The Leventhal et al. (1984) common-sense theory applied to these results provides further explanation. Common-sense theory proposes that people cope with difficulties using a variety of resources. Seeking mental health services may be one of many options people consider when faced with personal problems. This study appears to indicate that seeking help from a mental health professional is the last choice among many, if not most, USAF members.

As part of this theory, this selection may be based upon social comparison. Any USAF member having personal problems will examine the coping strategies of other USAF members. If the results of this study are indicative, USAF members will not select services from the base mental health clinic because this action is viewed negatively among them.

Distressed USAF members may not even represent their problems as being psychological in nature. Many respondents seemed to indicate that "personal problems" are religious or character problems and that mental health professionals cannot help with these problems or may, in fact, exacerbate them. Therefore, from a common-sense perspective, the results of this study may indicate that seeking mental health services is simply not a coping strategy considered by most USAF members.

Rational Theory

The USAF is more than a collection of individuals; it is an organization or perhaps even a culture. Therefore, rational theory, which is an organizational

theory, was also applied to this analysis. This theory posits that organizations socialize members with values, norms, and "acceptable behavior" (Denhart, 1981). From this perspective, not seeking professional psychological help appears to be the accepted behavior and socially accepted norm. Among the survey responses, several wrote that USAF leaders verbally encourage help seeking but often hinder help-seeking efforts. The message the respondents received was not to seek help.

The results of this study also indicate that the barriers to accessing mental health services are more than simply norms of the organization. From a rational perspective, these barriers may, in fact, reinforce the primary mission of the USAF: combat. As some respondents indicated, people with "problems" are not accepted within the USAF because they are seen as unable to fulfill their part of the organization's mission. Therefore, these barriers, rather than being undesirable hindrances, may be effective ways to keep USAF members from admitting their problems. As a consequence, the USAF appears to be healthier than it is because its members avoid seeking help. USAF members' problems, however, may be manifesting themselves in other ways such as heavy drinking and suicide.

Breaking Down Barriers and Providing Help in the U.S. Air Force

In order to combat the mental health problems so prevalent in the USAF, the barriers to accessing mental health services must be alleviated or significantly curtailed. In this section, alternatives to make these changes are explored. First, programs to change the perceptions of mental health services are discussed. All

USAF members are expected to participate in these programs; however, the results of this study indicate that never-married men should be especially targeted since they have the most negative views of mental health services and problems. In the next section, I examine ways to change the system in order to provide greater access to care. This analysis is based primarily on the results that indicate concern for confidentiality and negative career impact.

Changing the Perception of Mental Health Services and Problems

Increasing the accessibility of mental health services in the USAF will require changing attitudes and perceptions. All of the barriers discussed must be addressed in any change program, but the most important barrier to address is the stigma associated with help seeking; this factor was the most significant barrier noted by the sample. Changing attitudes associated with the stigma of mental health counseling may also be easier than changing the system itself. In other words, it may be easier to educate USAF members on mental health services than to change regulations, which compromise confidentiality.

Changing an organization's norms and culture is difficult. The attitudes and perceptions concerning mental health services in the USAF are part of an established paradigm in which new recruits are indoctrinated and military members perpetuate. Therefore, changing this paradigm cannot be expected to be quick or easy.

The military, however, should not be viewed as being impossible to change; in fact, it has successfully implemented dramatic reforms such as desegregation (a decade before the civil rights movement) (Butler, 1991). Presently, the military is responding to dramatic changes resulting from draw-downs, technological advances, and changing mission demands (Wheatley, 1994). Yet, changing the paradigm concerning mental health services is different from learning to operate the latest tank or to fly the newest plane.

Chin and Benne (1985) proposed a model for changing organizations that strikes at the heart of the organization's paradigm. Their normative reeducative strategy was based on the assumption that people are guided by values, habits, and internalized meaning, with change requiring work on personal, institutional, and sociocultural levels. The normative reeducative model challenges the cognitions and perceptions of people, as well as unconscious and preconscious motivations (Chin & Benne, 1985). This model contains numerous steps to promote change, with the most germane element for this study focusing on recognizing these unconscious motivations and examining their role on impending change. Chin and Benne stated, "Nonconscious elements . . . must be brought into consciousness and publicly examined" (p. 32).

Chin and Benne (1985) proposed using a change agent to guide organizational members through a self-examination process and to provide feedback. They suggested using personal counseling, training groups, and residential laboratories or workshops to promote experiences for individuals; that

is, lectures alone will not bring about the desired change. USAF leaders know the value of experience-based training. They stage war games to help USAF members prepare for the rigors of battle. However, lecture without experiences seems to be the only prerequisite for other areas such as sexual harassment and suicide prevention training. In order to change the perception of mental health services, USAF members must do more than listen. As this study indicated, most believed that an abundance of help was available and that the USAF leadership verbally encourages others to seek help. In order to change their perceptions, USAF members need experiences. These experiences may involve groups in which their perceptions are openly discussed and challenged; they may sit in groups and talk with a mental health professional about mental health issues and concerns; or they may be asked to participate in role-playing scenarios in which they are confronted about mental health issues and problems.

Another element in creating a more positive atmosphere for seeking mental health services involves assigning a mental health professional to units, which is much the same way that chaplains are assigned. These professionals would act as change agents who can provide on-going training and consultation (Chin & Benne, 1985).

The most important step in this normative reeducative process will involve USAF leaders. USAF leaders often are excluded from the extensive training required by their subordinates. In order to change the mental health paradigm, their participation will be essential. They must be active participants in this

process, including admitting that they have sought mental health services. As long

as USAF leaders encourage help seeking but have not sought help themselves, they

will continue to discourage help seeking subtly. A prominent general admitting

that he[1] sought mental health counseling and that it helped could profoundly

influence many in the lesser ranks to seek help.

Three other suggestions also may encourage changing perceptions of mental

health services among USAF members. Alone, none of these suggestions can be

expected to change attitudes substantially toward help seeking but along with other

steps may be helpful. The first step is to focus mental health efforts toward health

more than pathology. Several respondents suggested that mental health providers

should provide services more like coaches or motivational speakers than therapists.

One way to facilitate this change would be to have mental health providers attend

unit meetings and to give practical advice on daily living such as improving

relationships, accomplishing goals, thinking positive, and relaxation training. This

education may help many, but, more importantly, mental health providers may

appear to be more accessible as they increase their exposure. Along with this

change, altering the name of mental health clinics may also be helpful. Some units

have tried names such as the "Mental Hygiene Clinic" and "Life Skills Center."

This change alone is dubious, but in conjunction with other changes, it may be

helpful. Finally, a simple video explaining mental health services and help seeking

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[1]The pronoun "he" is used deliberately here because help seeking among
women is significantly higher than among men. A male general admitting seeking
help would more dramatically confront the help-seeking issue.

could be shown to all USAF members. Since most new arrivals at bases must attend orientations, a short (5 to 7 minutes) video could be a good starting point to change the perception of mental health services and problems.

An essential element in all of these programs to change attitudes will be to separate fact from fiction. No program advertising that seeking help will not hurt careers will be believed because, to some small degree, help seeking can hurt careers. Consequently, the system must also be modified.

Changing the System

Changing attitudes and perceptions is difficult, especially when there are substantial elements of truth to some of these perceptions. As the literature review indicated, seeking mental health services can be detrimental to a USAF member's career—although slight. The sample's perception that the military mental health system offers little confidentiality is exaggerated but to a substantial extent true.

The first step towards changing the system involves minimizing the negative career impact associated with help seeking. This study did not fully analyze all of the possible career implications of help seeking; however, the numerous comments concerning security clearances suggest that this area must be examined. Certainly, there are differences in the perceptions of some USAF members and the actual text of the security clearance regulations.

Another area of concern to the respondents was confidentiality. Recently, the USAF initiated a limited protection suicide prevention program that allows USAF members who are facing disciplinary action and who may be suicidal to

seek mental health services with limited confidentiality. However, the regulation covering this program (AFI 44-109) is written in legal terms; thus, deciding the exact extent of confidentiality would be difficult to understand for most mental health providers and potential clients. The regulation also does not go far enough.

The simplest step would be to provide military members with the same level of confidentiality given to civilians. This step, however, fails to consider the various functions of mental health services in the military and the unique nature of military service. Military mental health providers are responsible for more than simply supplying services for clients. They have a mandate to ensure that USAF personnel are mentally "fit for duty." These duties may involve hazardous jobs such as flying high performance aircraft or sensitive jobs involving national security or nuclear weapons. For these reasons, confidentiality is often violated. This reasoning, however, fails to consider that the lack of confidentiality discourages most from seeking help; therefore, relatively minor problems may be exacerbated. If promptly treated, these problems might be easily eliminated and improve job performance. Without help, these problems might ultimately cause harm to the member and others. Therefore, changes must be made to promote more confidentiality.

The solution to this problem is to provide strict confidentiality, except in some specific circumstances such as when a client is a threat to himself/herself or others or will be significantly impaired when performing hazardous duties. Outside of these conditions, mental health records should be strictly confidential.

The standard "need to know" would no longer apply. In order to implement this solution, mental health professionals would need additional training on confidentiality. In addition, a board should be established at every hospital to provide consultation on cases in which providers are unsure how to proceed in terms of confidentiality. Confidentiality outside of these criteria would be the same as offered in the civilian community.

One problem with this solution is that some mental health matters require the assistance of commanders and first sergeants. In cases involving domestic violence and substance abuse, commanders are often the reporters. Their assistance can also be helpful in motivating unwilling clients to participate. One possible solution to confidentiality concerns would be to delineate voluntary and involuntary clients. If USAF members are referred to these programs as a result of a complaint or police intervention, then the present rules concerning confidentiality should apply. This approach would be similar to a court that mandates treatment. On the other hand, those who seek help voluntarily would be provided the same level of confidentiality offered other clients.

Being seen at the mental health clinic, of course, was discouraging enough for many in the present study, which may always be a problem to some extent. Therefore, placing the mental health clinics in a location away from other services may provide some confidentiality. This approach has been taken at Hill Air Force Base in Utah; that is, the mental health clinic is located several miles from the base hospital.

Even with these changes, some USAF members will continue to avoid seeking help. Therefore, military mental health professionals must be proactive in their approach. As suggested by several respondents, USAF mental health professionals need to make themselves known. They should attend commanders' calls and advertise their services liberally. The U.S. army currently uses combat stress control units to accompany units in deployments and field exercises, as well as to provide routine mental health services daily. These combat stress control units focus on troop morale and, in general, look out for the mental and emotional well-being of the troops (Willis, 1997).

Another approach might be to establish a hot line for USAF members to call and talk about their problems. This step would provide complete confidentiality and allow members to talk about their problems with a professional. This professional could then steer USAF members to appropriate services, as well as to provide immediate support.

Additional Training for Helping Sources

Changing both the mental health system and the attitudes/perceptions of USAF members is essential to overcoming barriers to accessing mental health services; but these steps will be time consuming. A more immediate step involves training helping sources to be more responsive to various members and problems.

First, USAF mental health professionals must understand the military culture (Kutz, 1996). This step is particularly applicable to social workers who emphasize understanding people in their environments. USAF social workers must

strive to understand the needs, attitudes, and interests of USAF members and their families (Bowen, 1985). Additional training in understanding the military culture and barriers will help all mental health professionals to be more responsive to their clients.

Chaplains also need additional training. Regardless of the steps taken by mental health professionals, a substantial number of USAF members will continue to rely upon chaplains for assistance. Chaplains offer almost complete confidentiality and are experienced in spiritual matters, which were so important to many in this sample. USAF chaplains, however, have varying degrees of training in identifying mental health problems. Some are well-trained, whereas others may not be (W. Fretwell, USAF chaplain at Hill Air Force Base, Utah, personal communication, December 6, 1997). Therefore, USAF leadership should take two steps to ensure that those seeking help from chaplains receive the best care possible.

First, chaplains must receive minimal training to be able to identify mental illness, making appropriate referrals when necessary. This training would help chaplains decide which members they can adequately help and which cases may need additional psychiatric interventions. In addition, chaplains need a better understanding of the mental health system. Chaplains may, in fact, have the same perceptions and attitudes concerning mental health services as the remainder of the USAF population. The idea that chaplains are openly discouraging seeking help from military mental health professionals, as a respondent indicated, is troubling; it

creates a helping system that is fighting against itself. In order to help facilitate creating a more unified system, chaplains and mental health professionals should establish informal relationships.

These steps should also be taken with commanders and first sergeants. The results of this study indicate that these leaders often do not understand mental health problems; in fact, some are even hostile to help seeking. Because these leaders are often the most visible source of help, they must be trained to recognize mental health problems and to become more positive in their attitudes toward help seeking. The suicide prevention education program, to some degree, tries to accomplish this step but may be too narrowly focused. Presently, first sergeants receive better training in this area, with commanders appearing to have little knowledge in this area. This training may establish a more positive relationship between mental health professionals and USAF leaders.

Implications for Social Work Policy and Practice

The USAF is part of the broader American society. Therefore, in order to overcome barriers to accessing mental health services in the USAF also means overcoming barriers in society as a whole. From a broad policy perspective, social workers must continue in their tradition of advocating for the mentally ill. The social work position should be that everyone has a right to mental health care (Mizrahi, 1992). This position must be especially emphasized for minority groups and the rural poor who have numerous cultural, financial, and geographic barriers to service (Cowan, 1979).

Fellin (1996) offered several issues on mental health policies that must be debated. He stated that definitions of mental illness must be examined and that epidemiological research must start to influence policy. Despite strong evidence that mental health problems are pervasive and mental health services underutilized, federal and state policymakers are not taking steps to help. Fellin and others (Biegal, Shore, & Silverman, 1989) have discussed coordinating the efforts of community mental health centers to prevent the mentally ill from "falling through the cracks" of the system. Social workers should be especially involved in building community support for the chronically mentally ill (Runyan & Faria, 1992). Another step would be to provide comprehensive mental health insurance to all Americans. The decision to force insurance companies to treat physical and mental illnesses equally is being debated. Finally, social workers should join with other mental health professionals to form a united front to promote policy changes that benefit the mentally ill (Fellin, 1996).

From a social work practice perspective, social workers need to recognize that some of the barriers to accessing mental health services can be overcome. Understanding the cultural barriers can help facilitate therapeutic interaction and, consequently, increase the number of racial and ethnic minorities who seek help (Sue & Sue, 1977). In addition, social workers should advertise the benefits of therapy and seek ways of decreasing the financial cost of help seeking.

Unless social workers and other mental health professionals actively advocate to overcome the barriers of accessing mental health services, most people

with mental health problems will continue never to get the help they need.
Consequently, millions will suffer needlessly.

Limitations and Future Research

This study had limitations: The sample was self-selected, and this study
was the first to utilize the MATS. Future research with another sample and the
MATS is needed to verify the results in the present study. In addition, the
ATSPPH was helpful in understanding help-seeking attitudes, but it has never been
shown to predict help-seeking behavior (Fischer & Farina, 1995). Future research
might address a sample over time, measuring help-seeking attitudes at one point
and accessing behavior at another. Finally, this study clearly showed that USAF
members hold attitudes and perceptions that hinder help-seeking behavior. With
several programs being tested in the USAF to increase help seeking, another study
of these barriers in a few years may indicate the effectiveness of these programs.

APPENDIX A

SURVEY COVER LETTER

From: Fred P. Stone, Capt, USAF, BSC

To: Survey Participants

Subject: Attitudes Toward USAF Services

1.   Recent rises in mental-health-related problems have highlighted that USAF members may avoid seeking mental health services. This survey hopes to identify some of the reasons for this avoidance so that some recommendations for changes can be made.

2.   You have been selected at random to participate in this survey. Your participation is totally VOLUNTARY. If you choose to participate, please fill out the attached survey and return it in the envelope enclosed with this letter. **Your responses are confidential and private, and it will be impossible for me or anyone else to identify you from this survey.**

3.   I appreciate your participation in this research. If you have any questions or concerns, please contact me at (801)581-6236. You can also contact me via e-mail at 73004,2411@compuserve.com.

FRED P. STONE, Capt, USAF, BSC
Air Force Institute of Technology

APPENDIX B

SURVEY INSTRUMENT

Military Survey of Attitudes Towards Services

The USAF provides a variety of services that are intended to help members and their families. Whether or not USAF members actually believe these services are helpful is vital if they are going to be changed or improved. This is why you are being asked to fill out this survey. Please respond to each question from **YOUR** point of view. **Again, your participation is totally voluntary and responses are strictly private and confidential.**

Please circle responses and fill in blanks as appropriate:

Rank: E1-E4   E5-E6   E7-E9   O1-O3   O4+

Age: ____   **Sex:**   Male   Female

Current Marital Status: Married   Divorced   Never Married   Other:_____

Highest Educational Level Attained: High School   Some College   College Degree   Graduate Degree   Other:_____

Race/Ethnicity:_____   **First Number of Your AFSC:**_____

This set of questions concerns "personal problems" or serious troubles such as depression, thoughts of suicide, abusing alcohol, or physical fights with a spouse or friend.

For each of the following statements, fill in the blank with each of the four selections and circle the degree you agree with the statement using this scale:

    1=Disagree   2=Partly Disagree   3=Partly Agree   4=Agree

For personal problems or serious troubles, I think:

	Disagree			Agree

1. USAF members' careers will be hurt if they talk with military...................................	Chaplains	1 2 3 4
	Mental Health Professionals	1 2 3 4
	Commander/First Sergeants	1 2 3 4
	Medical Doctors	1 2 3 4
	Friends	1 2 3 4
2. USAF members' problems are kept confidential (private) when they talk to...............	Chaplains	1 2 3 4
	Mental Health Professionals	1 2 3 4
	Commander/First Sergeants	1 2 3 4
	Medical Doctors	1 2 3 4
	Friends	1 2 3 4
3. I have a lot of faith in the skills of military	Chaplains	1 2 3 4
	Mental Health Professionals	1 2 3 4
	Commander/First Sergeants	1 2 3 4
	Medical Doctors	1 2 3 4
	Friends	1 2 3 4
4. USAF members would be embarrassed if others knew they had seen military.............	Chaplains	1 2 3 4
	Mental Health Professionals	1 2 3 4
	Commander/First Sergeants	1 2 3 4
	Medical Doctors	1 2 3 4
	Friends	1 2 3 4
5. Most USAF members would feel weak if they talked to military	Chaplains	1 2 3 4
	Mental Health Professionals	1 2 3 4
	Commander/Supervisors	1 2 3 4
	Medical Doctors	1 2 3 4
	Friends	1 2 3 4

(PLEASE CONTINUE ON THE BACK)

Please use the following numbers to indicate the level you agree or disagree with the following statements:

1=Disagree
2=Partly Disagree
3=Partly Agree
4=Agree

___6. If I thought I was having a nervous breakdown, my first thought would be to get professional help.

___7. Talking to a mental health professional is a poor way to get rid of emotional problems.

___8. If I was having a serious emotional problem, I would be confident that a mental health professional could help.

___9. I admire people who are willing to cope with their problems and fears without resorting to professional help.

___10. I would want to see a mental health professional if I was worried or upset for a long period of time.

___11. I might want to have mental health counseling in the future.

___12. A person with an emotional problem will solve it with professional help.

___13. Considering the time and expense involved in mental health counseling, I doubt it would help a person like me.

___14. A person should work out his or her own problems and get mental health counseling only as a last resort.

___15. Personal and emotional problems tend to work out by themselves.

___16. The USAF has plenty of help for me if I have any personal or emotional problems.

___17. I think that USAF mental health professionals often "make a big deal" out of small matters.

If you would like to comment on any of the questions or your answers, please do so below:

Circle yes or no.

18. Have you ever voluntarily talked to a military mental health professional about any problem of yours?   Yes   No

19. Have you ever been forced or coerced into talking to a military mental health professional?   Yes   No

20. If you answered "no" to questions 18 and 19, then have you ever seriously considered seeking military mental health services for yourself?   Yes   No

21. Have you ever seen a civilian mental health professional because you didn't want to go to the base mental health clinic?   Yes   No

If you would like to comment on any of the questions or your answers, please do so below:

Note. These questions have been modified from the original. Questions 6 through 15 are taken from "Attitudes Toward Seeking Professional Psychological Help: A Shortened Form and Considerations for Research" by E. H. Fischer and A. Farina, 1995, Journal of College Student Development, 36(4), 368-373.

APPENDIX C

SURVEY INSTRUMENT CONSTRUCTION

Test Construction: A Military Survey
of Attitudes Towards Services

An increasing number of mental health problems among members of the

USAF has been well-documented. The suicide rate has increased dramatically over

the last decade (Helmkamp & Kennedy, 1996) and is presently 50% higher than

the civilian rate (Jowers, 1996a). Rates of domestic violence have also increased

despite Department of Defense efforts to curb the problem (L. Besetney, research

psychologist, family advocacy program, electronic mail, May 5, 1997; Jowers,

1996b). In addition, USAF members are more likely to drink alcohol and to drink

heavily than their civilian counterparts (Bray et al., 1992); also, those exposed to

combat suffer disproportionately from posttraumatic stress disorder (Fontana &

Rosenheck, 1994).

Despite these mental health concerns, USAF members rarely use the mental

health services available to them. Only 2% to 3% of USAF members use mental

health services each year (Bray et al., 1992; Crosby & Hall, 1992; Rowan, 1996)

compared to 6% in the civilian community (Olfson & Pincus, 1994a).

While directly comparing these rates is problematic because of differences

in these communities, the consensus among mental health professionals in the

USAF is that members of the USAF avoid seeking mental health services,

hereafter referred to as help seeking, because of a variety of attitudinal and

perceptual barriers (Jowers, 1996b; Rowan, 1996). Unfortunately, these barriers

have never been studied. One reason researchers may have avoided examining

these barriers is that a simple, reliable instrument measuring this phenomenon is

unavailable. Consequently, I developed this instrument to examine the attitudinal and perceptual barriers that may prevent USAF members from accessing mental health services.

Construct Definition

In order to construct this instrument, I first needed to define "attitudinal and perceptual barriers in accessing mental health services among USAF members." Webster defines barrier as an impediment (Gove, 1986). Building on this idea, attitudinal and perceptual barriers are defined as attitudes and perceptions that deter or impede USAF members from accessing mental health services.

This construct has the following four components:

1.   A perception that seeking mental health services will hurt USAF members' careers (Jowers, 1996a). In other words, USAF members may perceive that seeking help for a mental health problem will jeopardize their military careers, which may be one of the reasons they avoid these services.

2.   A perception that USAF mental health services do not offer complete confidentiality (Howe, 1989). USAF members may believe that whatever they tell a USAF mental health professional will be passed on to their supervisors and commanders. As a result, they may avoid seeking help.

3.   Negative attitudes toward seeking mental health services, mental health problems, and mental health providers. USAF members may avoid mental health services because they fear the stigma associated with mental health problems and distrust mental health professionals, which is consistent with the attitudes

found in the civilian community (Fellin, 1996). Consequently, they avoid seeking help.

4.   <u>Lack of knowledge concerning the availability of mental health services.</u> McCarroll and colleagues (1993a) found that some military members may be unaware of their mental health benefits and, thus, not seek professional mental health services.

Several theories helped in defining this construct. Fischer and Turner (1970) developed a theory of help seeking, which posited that people with more positive attitudes toward seeking professional psychological help were more likely to seek help. They found that help seekers were more likely to (a) recognize a need for professional psychological help, (b) tolerate stigma well, (c) be interpersonally open, and (d) have confidence in mental health professionals.

The theories of Fischer and Turner (1970) and Fischer and Farina (1995) directed me to examine attitudes toward help seeking as a component of the help-seeking decision. In other words, I began investigating what attitudes USAF members have toward seeking mental health services and whether or not these attitudes are consistent with those found in the larger civilian community. Consequently, the instrument I constructed includes items concerning attitudes toward help seeking.

In addition, I looked at various organizational theories in order to evaluate the impact that the military organization may have on the help-seeking decisions of its members. Several theories were helpful, but the normative reeducative theory

of organizational change was the most informative (Chin & Benne, 1985). Chin and Benne theorized that organizations try to instill values, habits, and internalized meanings of events in workers. This theory suggests that the military organization directly or indirectly indoctrinates members with norms, values, and meanings related to seeking mental health services. Therefore, the instrument I constructed needed to evaluate the norms, values, and meanings of mental health services in the USAF but not those of individual members.

Instrument Overview

Selecting the item and response format for this instrument was challenging. Initially, the instrument contained 30 statements in which respondents agreed or disagreed. This format, however, failed to indicate the prevalence of barriers; therefore, another format in which respondents measured subcomponents of the construct for various groups was substituted. Respondents measured the prevalence of the first three components of the barrier construct with chaplains, mental health professionals, commanders/first sergeants, medical doctors, and friends.

The instrument used in the pilot test contained 19 items but did not include demographic questions (Appendix B). Questions 1 and 5 examined the perception that seeking mental health services damages USAF members' careers. The degree to which USAF members have confidentiality was measured by Questions 2 and 6, whereas the negative attitude of seeking mental health services for mental health problems was measured by Questions 4 and 7. Whether or not USAF members

have confidence in the skills of mental health professionals and others was measured by Question 3. Question 19 makes a similar inquiry, although it only asks about mental health professionals. Knowing whether or not services are available is a barrier regardless of the availability of other services; Question 18 directly inquires about the fourth barrier concerning the availability of mental health services. Questions 8 through 17 were adapted from the ATSPPH (Fischer & Farina, 1995). The sum of the ATSPPH indicates a general attitude towards help seeking. This published measure should provide information that is more broadly generalizable.

Respondents were asked to rate their answers on a 4-point scale (1 = disagree, 2 = partly disagree, 3 = partly agree, and 4 = agree). I used this scale for two reasons. First, this scale is consistent with the scale used by Fischer and Farina (1995), and consistency throughout the instrument made it easier to take. Second, by not offering a neutral response, respondents were forced into a decision concerning their attitudes, and it provided more extreme scores in which most item-analytic methods depend (Kline, 1986).

In order to analyze responses, several calculations were made. First, after reverse scoring Questions 9, 12, 15, 16, and 17, Questions 8 through 17 were totaled for an overall attitude towards help seeking. Next, totals from Questions 1 through 7 were tabulated across categories; for example, all responses concerning chaplains were totaled. This step provided a composite score for each helping category. Finally, the total for all helping categories was summed for each

question.

Item Pool Generation

I conducted an extensive review of the literature concerning barriers to accessing mental health services in both the civilian and military communities. From this analysis, many items were generated, with several discarded and others rephrased. During this process, feedback from 18 USAF members was solicited. They universally agreed that the identified factors were the essential elements of the barrier construct. No one offered other factors. This sample also included several USAF mental health professionals from Hill Air Force Base. Their agreement that the construct was accurate and complete supported the face validity of the instrument. Many of the respondents objected to the language used in Questions 8 through 17. Specifically, they believed that several USAF members would not understand the term "psychotherapy." This term was replaced. They also believed the instrument was too long; as a result, it was shortened to 1 page (front and back). Other suggestions included providing a sample question, changing the instructions, and modifying the response layout. Different questions, formats, and many instructions were substituted; also, an instrument suitable for testing larger samples was developed after many revisions.

Data Collection

Thirty-eight USAF cadets were sampled to evaluate the instrument. Ideally, the sample would have included USAF members, but the cadets had 1 or more

years of education and experience with the USAF. In addition, the restrictions surrounding sampling USAF members would have made it impossible to complete this assignment in the allotted time.

In order to evaluate the instrument with cadets, I attended four class sessions and administered the instrument during the first 10 minutes of class. I emphasized the voluntary nature of the survey and asked the cadets to note any problems or typographical errors in the instrument. During the first two samplings, several respondents noted two small typographical errors; these were corrected during subsequent tests.

Results of Item and Scale Analysis

Because the properties of the ATSPPH had been examined (Fischer & Farina, 1995), I mainly focused on looking at the first seven questions of the instrument in order to evaluate their testing properties. Initial frequency data of the 35 completed instruments showed that 1 respondent did not complete these questions, whereas 2 others seemed to circle blocks of responses. These last 2 response sets were dramatically different from the remainder of the sample and internally inconsistent with the matched questions. Therefore, their responses were not counted, leaving the sample at 32.

The instrument was examined from two perspectives. First, totals across helping sources were compiled (i.e., responses for chaplains, mental health professionals, commanders, medical doctors, and friends). Table 25 displays the means and standard deviations for these totals.

Table 25

Means, Standard Deviations, and Cronbach's Alpha of the Military Survey of
Attitudes Toward Seeking Help From Chaplains, Mental Health Professionals,
Commanders, Physicians, and Friends

Helping source	N	X̄	SD	p
Chaplains	32	10.9	2.8	.590
Mental health professionals	32	17.9	4.4	
Commanders/first sergeants	32	18.0	3.8	
Physicians	32	16.6	4.4	
Friends	32	14.6	3.9	

Larger scores indicate a higher level of barriers with each source. When
looking for help for personal problems, the sample perceived the greatest barriers
to be with commanders and mental health professionals. This result was expected,
but the fact that commanders (who have the role of administering punishment) and
mental health professionals (who are supposed to help) have almost identical scores
is interesting. Another expected result was that chaplains were perceived as a less
threatening source of help than friends. The variability of this finding is small and
appears to be consistent across all respondents compared to other results.
Cronbach's alpha indicates that 59% of the variance was due to the difference in
the true score (Croker & Algina, 1986). If this instrument was unidimensional, a
higher alpha might have been expected; however, this result was expected
considering the diversity of the helping sources. An extremely high alpha might
have indicated that there was little difference between these sources of help. The

correlations show that few of the helping sources were significantly correlated with each other, which is consistent with Cronbach's alpha results (Table 26).

As might be expected, physicians and mental health professionals were moderately correlated (Hinkle et al., 1994). Because they both work for the hospital and share similar professional status, the subjects may have seen themselves as similar helping sources. Surprisingly, the correlation between physicians and commanders was also moderate (Hinkle et al., 1994). Finding an explanation for this result was difficult; thus, further investigation of the relationship between these sources may be warranted.

The second perspective from which this test was examined looked at the relationship between each question. Because each question examined a different barrier to accessing help, the evaluation of the relationship between questions was also an evaluation of the relationship between barriers. The internal consistency was .77, which was higher than that for the helping categories. The internal consistency of the barriers indicates that while there were some differences between barriers there were also expected differences.

The potential range of the mean scores for these questions was between 5 and 20, with higher scores indicating that respondents agreed that these factors were barriers to receiving help. A score above 12.5 indicates that more respondents agreed that the barrier in question was significant. However, only Question 6 (confidentiality) was higher than 12.5 (Table 27). This sample did not perceive these barriers as representative or important across helping professionals.

Table 26

Correlations of Helping Sources and Barriers

	Chaplains	Commanders	Friends	Physicians	Mental health professionals
Chaplains	1.00				
Commanders	.23	1.00			
Friends	.15	.38	1.00		
Physicians	.18	.63	-.09	1.00	
Mental health professionals	-.11	.30	-.12	.56	1.00

Table 27

Means, Standard Deviations, and Internal Consistency Alpha of the Different Barriers to Accessing Mental Health Services for Members of the U.S. Air Force

Question	$\underline{N}$	$\overline{X}$	$\underline{SD}$	$\underline{p}$
1 Negative career impact	32	10.6	3.09	.772
2 Confidentiality	32	11.9	2.81	
3 Faith in professionals	32	9.5	2.17	
4 Stigma	32	10.3	2.96	
5 Negative career impact	32	11.5	2.69	
6 Confidentiality	32	13.1	2.25	
7 Personal weakness	32	11.1	2.28	

Two additional explanations of this finding are possible. First, because the sample consisted of cadets and not actual USAF members, they may have had different perceptions of barriers. Second, because the impact of these barriers was expected to be different with different helpers, it is not surprising that the scores would average to be almost neutral.

Correlations among the questions indicated varying degrees of relationships. Questions 1 and 5 addressed the fear of negative career impact related to seeking help, with a high correlation expected (Table 28). Questions 2 and 6 asked about confidentiality, but the correlation was low (r = .48) (Hinkle et al., 1994). This finding indicated that the questions may be asking about two related but somewhat different concepts. Question 2 seemed to be more general, whereas Question 6 was more specific. Questions 4 and 7 were significantly correlated (Hinkle et al., 1994), which was expected. Little difference was found between the stigma associated with seeking help and personal feelings of "weakness" for help seeking. Overall, none of the correlations was significant enough to indicate that the questions were repetitive. Still, since brevity may have helped in data collection, Questions 5, 6, and 7 were eliminated from the final test.

Questions 18 and 19 were also evaluated. The results of Question 18 revealed that the majority of respondents agreed that an abundance of mental health services was available. This question was inappropriate for the sample because they were not entitled to medical care from the USAF. Questions 3 and 19 were correlated. The Pearson correlation was .415 and significant; however, the

Table 28

Correlations of Items Measuring Barriers to Accessing Mental Health Services

	Q 1	Q 2	Q 3	Q 4	Q 5	Q 6	Q 7
Q 1	1.00						
Q 2	.43	1.00					
Q 3	.18	.18	1.00				
Q 4	.47	.02	.14	1.00			
Q 5	.75	.45	.19	.50	1.00		
Q 6	.31	.48	.09	.03	.49	1.00	
Q 7	.54	.06	.03	.70	.53	.19	1.00

Note. The "Qs" correspond with the instrument questions in Appendix B.

Spearman correlation, which was the more appropriate test, was only .30 and not significant. Evaluating this result was difficult because the sample had little direct experience with military mental health services. In fact, 7 members of the sample failed to answer this question.

Conclusions From Item Tryout

Constructing this instrument was a lengthy and time-consuming process. More accurately, this instrument evolved more than it was constructed. The first draft was 7 pages in length. From the feedback in class and initial interviews, I reduced the final product to 1 page (front and back). Because the mean of the question related to professional competence was lower than the other means and

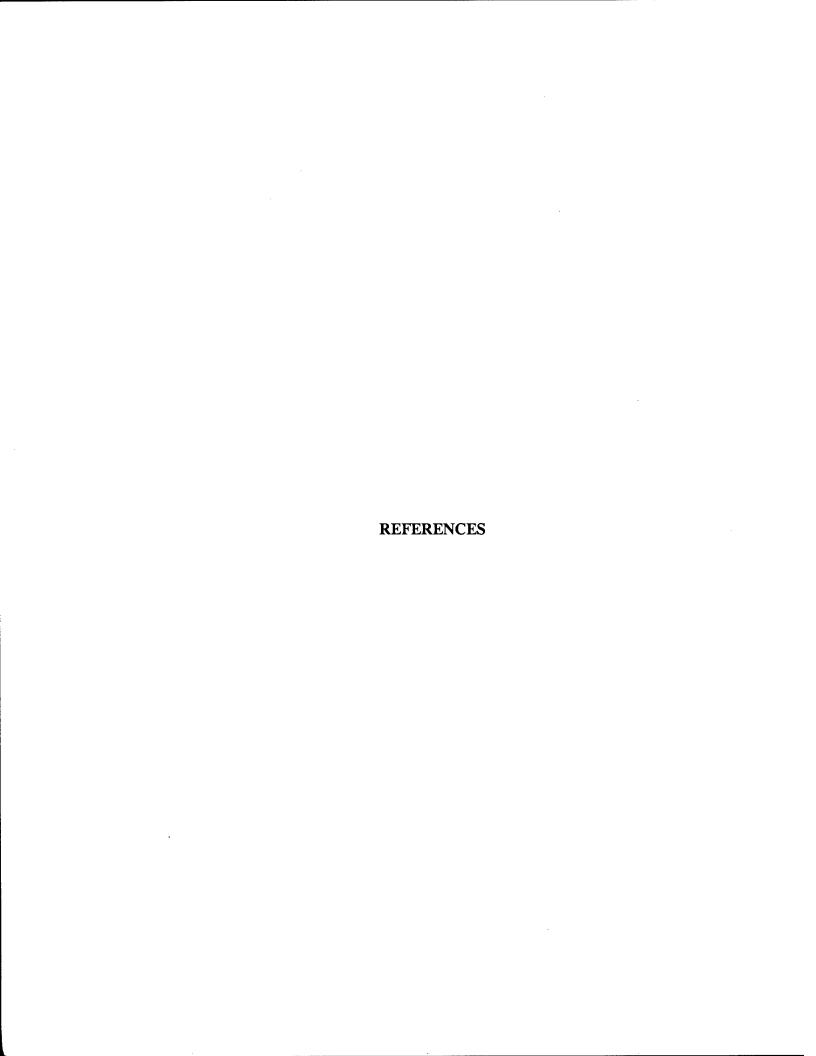was negatively correlated for some help sources, this question was reworded. "Confidence" was changed to "have a lot of faith in." This change may make it easier for future respondents to understand the question. On the other hand, USAF members may have more confidence in helping sources than currently reported in the literature. Some respondents indicated that the word "confidential" also may be confusing or unknown to future respondents; thus, the word "private" was added in parentheses to the final test. Overall, the test appears to measure the construct in question adequately. Unfortunately, this conclusion is based upon the results obtained from USAF cadets. A further study using active-duty USAF members is warranted.

Designing Future Reliability and Validity Studies

Several elements may have undermined the reliability and validity of this test. Because this test was administered on only one occasion, test-retest reliability was not established. Future research should evaluate this element of reliability.

Establishing convergent and discriminant validity was difficult for this test because of its unique nature. Because the ATSPPH measures attitudes toward seeking professional psychological help and not barriers to accessing mental health services, drawing conclusions from a comparison of these instruments is difficult. Totals of the ATSPPH were correlated with the results of Question 3, which related to respondents' confidence in the skills of mental health professionals. This correlation was .25, which is low (Hinkle et al., 1994), and may indicate differences in the confidence of mental health professionals in the civilian and

military communities. Again, however, the results with this sample may be questionable. Future tests should focus on using a sample more representative of USAF members.

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